JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY
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October 2025

Dear Participant:

The Patient Protection and Affordable Care Act ("PPACA") requires group health plans, such as the Pension, Hospitalization and Benefit Plan ("PHBP") of the Electrical Industry, to furnish participants with a Summary of Benefits and Coverage or "SBC." The SBC is a summary of material provisions of a health plan in a uniform format.

Enclosed please find the SBC for the PHBP for the coverage period beginning on October 1, 2025. This document summarizes the key features of the Plan such as covered benefits, cost-sharing provisions, coverage limitations, and coverage examples and exceptions. We recommend you retain a copy of the SBC with your other PHBP records.

Please note that while such terms as "premiums" and "co-insurance" are required by federal regulations to appear in the SBC, they may not apply to your Plan.

For a more complete explanation of the PHBP's rules, covered and excluded benefits and cost-sharing provisions, please refer to your Summary Plan Description ("SPD") and Summaries of Material Modifications ("SMMs"), all of which can be found at https://www.jibei.org/health/phbp-medical-and-rx-plan/.

If you have any questions concerning the SBC, please contact the Hospitalization Department at the Joint Industry Board at (718) 591-2000, ext. 1350.

Sincerely,

Joint Industry Board of the Electrical Industry

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://www.jibei.org/health/phbp-medical-and-rx-plan/ or call 1-718-591-2000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 1-718-591-2000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**2025-2026** $1,000 individual/ $2,000 family	Generally, you must pay all of the costs from providers up to the deductible before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. If an individual meets the individual deductible, the plan will cover benefits for that individual only, and the deductible will apply to the remainder of the family until the overall family deductible is met.
Are there services covered before you meet your deductible?	Yes. Preventive services, prescription drugs, services rendered at JIB Medical P.C. or by internists, primary care, pediatrics, obstetrics/gynecology (OB/GYN), behavioral health and physical therapy providers, telehealth visits, and MDLive primary care and urgent care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Network providers: **2025** $9,200 individual/ $18,400 family **2026** $10,600 individual/$21,200 family The overall out-of-pocket limit does not apply to services provided by non-Network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit?	Out-of-pocket costs for non-Network providers, balance-billing charges (where permitted by law), penalties for failure to obtain preauthorization and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a Network provider?	Yes. See www.magnacare.com or call 1-877-624-6210 for a list of Network providers.	This plan uses a provider Network. You will pay less if you use a provider in the plan's Network. You will pay the most if you use an non-Network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your Network provider might use a non-Network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit* Deductible does not apply.	$35 copay/visit* Deductible does not apply.	* Higher copayment applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical. See the May 2025 Summary of Material Modifications (SMM) to the SPD for more information. $25 copayment for acute care visits to JIB Medical, PC. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	$50 copay/visit*	$50 copay/visit*	
	Preventive care/screening/ immunization	No charge	$35 copay/visit*	

For more information about limitations and exceptions, see plan or policy document at https://www.jibei.org/health/phbp-medical-and-rx-plan/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray blood work*)	$35 copay/test* Deductible does not apply.**	$35 copay/test* Deductible does not apply.**	* Higher copayment applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical. See the May 2025 SMM to the SPD for more information. When required by law, non-Network diagnostic tests and imaging will be covered as Network. ** Check the "Are there services covered before you meet your deductible?" section on page 1 of this SBC for more information.
	Imaging (CT/PET scans, MRIs)	$100 copay/test	$100 copay/test	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or by calling Express Scripts at (800) 818-0883 or Accredo Specialty at (800) 803-2523.	Generic drugs	**For active Participants:** $20 retail/prescription $40 mail order/prescription **For retired Participants:** $15 retail/prescription $35 mail order/prescription	**For active Participants:** $20 retail/prescription $40 mail order/prescription **For retired Participants:** $15 retail/prescription $35 mail order/prescription	You pay the difference between the cost of the non-generic and the generic equivalent, if available. You may make one fill and one refill for maintenance medication at an in-person pharmacy before they must be filled via Mail Order. Preauthorization is required for some drugs or coverage could be lost. Your costs for some Specialty drugs could be as low as $0 if enrolled in the SaveOn Program. For more information, contact a SaveOn representative at (800) 683-1074. Retail prescriptions are limited up to a 34-day supply. Mail orders prescriptions are limited up to a 90-day supply.
	Preferred brand drugs	**For active Participants:** $40 retail/prescription $90 mail order/prescription **For retired Participants:** $30 retail/prescription $70 mail order/prescription	**For active Participants:** $40 retail/prescription $90 mail order /prescription **For retired Participants:** $30 retail/prescription $70 mail order/prescription	
	Non-preferred brand drugs	**For active Participants:** $80 retail/prescription $160 mail order /prescription **For retired Participants:** $60 retail/prescription $165 mail order/prescription	**For active Participants:** $80 retail/prescription $160 mail order/prescription **For retired Participants:** $60 retail/prescription $165 mail order/prescription	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Specialty brand drugs	**For active Participants**: $60 retail/prescription $120 mail order/prescription **For retired Participants:** $45 retail/prescription $105 mail order/prescription	**For active Participants:** $60 retail/prescription $120 mail order /prescription **For retired Participants:** $40 retail/prescription $105 mail order /prescription	You will pay the same mail order copayment regardless of whether the quantity is 90 days or a lesser amount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/procedure	$100 copay/procedure	Preauthorization required or coverage could be lost.
	Physician/surgeon fees	$500 copay/procedure	$500 copay/procedure with a $1,000 out-of-pocket limit*	Preauthorization required or coverage could be lost. * $500 copayment is not included in this out-of-pocket limit. When required by law, non-Network physician and surgeon fees will be covered as Network.
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	ER copayment waived and $500 in-patient copayment applies if admitted to inpatient hospital care.
	Emergency medical transportation	$100 copay	$100 copay	If air ambulance is needed, preauthorization required or coverage could be lost.
	Urgent care	$75 copay/visit	$75 copay/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission plus $200/day (up to $1,000)	$500 copay/admission plus $200/day (up to $1,000)	Preauthorization required or coverage could be lost. Copayments for certain ancillary services are not included in this limit. See the Hospital and Facility Based Benefits section of the current SPD for more information.
	Physician/surgeon fees	$500 copay/procedure	$500 copay/procedure with a $1,000 out-of-pocket limit*	Preauthorization required or coverage could be lost. * $500 copayment is not included in

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				this out-of-pocket limit. When required by law, non-Network physician and surgeon fees will be covered as Network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit Deductible does not apply.	$35 copay/visit Deductible does not apply.	$65 copayment applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical.
	Inpatient services	$500 copay/admission plus $200/day (up to $1,000)	$500 copay/admission plus $200/day (up to $1,000)	Preauthorization required or coverage could be lost. No copayment for elective inpatient substance abuse rehabilitation. Copayments for certain ancillary services are not included in this limit.
If you are pregnant	Office visits	$35 copay/visit* Deductible does not apply.**	$35 copay/visit* Deductible does not apply.**	* $65 copayment applies if you or your spouse has not received an annual physical. ** If services are billed by an OB/GYN or primary care provider. Copayments for certain ancillary services are not included in this limit. Depending on the type of services, a copayment or deductible may apply. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	$500 copay/delivery Deductible does not apply.**	$500 copay/delivery Deductible does not apply.**	
	Childbirth/delivery facility services	$500 copay/admission plus $200/day (up to $1,000)	$500 copay/admission plus $200/day (up to $1,000)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization of service and number of visits required or coverage could be lost. $65 copayment applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical. * See the Limitations of Benefits section of the current SPD for more information on limits for occupational, speech and physical therapy. ** Check the "Are there services covered before you meet your deductible?" section on page 1 of this SBC for more information. *** First 4 visits require copayment; no copayment required after 4 visits.
	Rehabilitation services*	$35 copay/visit*** Deductible does not apply.**	$35 copay/visit*** Deductible does not apply.**	
	Habilitation services	Not covered	Not covered	None.
	Skilled nursing care	No charge	No charge	Preauthorization of service and number of visits/units required or coverage could be lost. * Copayment does not apply to diabetic supplies.
	Durable medical equipment	$100 copay*	$100 copay*	
	Hospice services	No charge	No charge	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 exam limit every 12 months.
	Children's glasses	No charge	Not covered	Out-of-pocket expenses may be incurred for extra items. See the Optical Benefits section of your current SPD for further limitations.
	Children's dental check-up	Not covered	Not covered	None.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Maternity benefits for dependent children
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (through JIB Medical, PC only)
- Bariatric surgery (preauthorization required)
- Chiropractic care (30 visit limit)
- Non-emergency care when traveling outside the U.S.
- Hearing aids
- Infertility treatment
- Routine eye care (Adults) through Jena Optical for all Participants or, for those who are non-NYC residents, General Vision Services or Vision Screening (non-NYC resident retirees may go to any provider and receive up to a $56 reimbursement)
- Routine foot care
- Weight loss programs (through JIB Medical, PC only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1-718-591-2000 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 718-591-2000.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-Network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Office visits copayment	$35
Hospital (facility) cost-sharing	$700
Delivery services copayment	$500

This EXAMPLE event includes services like:
OB/GYN office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Prescription drugs

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$2,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

Managing Joe's type 2 Diabetes
(a year of routine in-Network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$50
Primary care copayment	$35
Prescription drugs copayment	$60

This EXAMPLE event includes services like:
Primary care physician office visits
Specialist care (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs (*insulin*)
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

Mia's Simple Fracture
(in-Network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$50
Emergency room copayment	$250
Rehabilitation services copayment	$35

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$1,940**

*Note: While the plan's overall deductible is $2,000, since this is an individual patient, these numbers assume the $1,000/individual deductible applies. See "What is the overall deductible?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.