JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY
158-11 HARRY VAN ARSDALE JR. AVENUE • FLUSHING, N.Y. 11365
TEL: (718) 591-2000 • FAX: (718) 380-7741• www.jibei.org

November 2023

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, 2023 and a Summary Material Modification Notice advising participants that the Trustees adopted prescription drug copayment changes to the Welfare Plan effective January 1, 2024. In addition, please find a Plan Design Clarifications Notice that applies to Medicare eligible retirees only.

The SBC 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," "co-insurance" and "deductibles" are required by federal regulations to appear in the SBC, they do 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 and updating Summaries of Material Modifications, all of which can be found at www.jibei.org.

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

PENSION HOSPITALIZATION AND BENEFIT PLAN
JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY
158-11 HARRY VAN ARSDALE JR. AVENUE • FLUSHING, N.Y. 11365
TEL: (718) 591-2000 • FAX: (718) 380-7741• www.jibei.org

October 2023

Plan Design Clarifications

Dear Medicare-Eligible Retiree:

We are writing to clarify the Annual Out-of-Pocket Limit section of our August 2022 Notice regarding changes to benefits for Medicare-eligible retirees in the Pension, Hospitalization and Benefit Plan of the Electrical Industry (the "Plan").[1]

Contrary to what was stated in the August 2022 Notice, no annual out-of-pocket limit applies to the benefits for Medicare-eligible retirees under the Plan, including amounts attributable to co-insurance, copayments, deductibles, premiums and out-of-network benefits. Medicare acts as the Primary Payer for Medicare-eligible retirees' medical benefits meaning that Medicare is the **first** to pay the costs associated with covered services, including deductibles, copayments and co-insurance. The Plan is a Secondary Payer meaning it pays or reimburses all or a portion of the remaining balance **following** Medicare's payment up to amounts specified in the Summary of Benefits and Coverage (SBC).

Therefore, your total out-of-pocket costs for covered services under the Medicare-eligible Plan will depend on:

- The services you obtain and their respective costs,
- How much of the costs Medicare covers, and
- How much of the remaining balance the Plan reimburses or pays.

For more information on how much the Plan pays or reimburses for covered services or how the Plan coordinates benefits with Medicare, please refer to the most recent SBC and the "**Benefits for Retirees Covered under Medicare**" and "**Coordination of Benefits**" sections of the Summary Plan Description (SPD).

If you have further questions, you may contact the Plan at **(718) 591-2000, ext. 1350.**

Sincerely,
Trustees of the Pension, Hospitalization and Benefit Plan of the Electrical Industry

[1] Per the Plan's terms, the Plan only provides benefits to Medicare-eligible retirees if they also enroll in Medicare. Please refer to the Summary Plan Description for more information.

EXPRESS SCRIPTS®
P.O. BOX 66773
ST. LOUIS, MO 63166-6773

Prescription Plan Benefit Plan
Changes Effective January 1, 2024

Dear Participant:

With the rising cost of prescription drugs, the Trustees of the Pension, Hospitalization and Benefit Plan of the Electrical Industry ("PHBP") have adopted drug copayment changes applicable to the Welfare Plan.

Effective January 1, 2024, the following copayments will apply for active and retired participants and their eligible dependents.

	Active Participants and Dependents		Retired Participants and Dependents	
	Retail Pharmacy Up to 34-Day Supply	**Mail Order 90-Day Supply[1]**	**Retail Pharmacy Up to 34-Day Supply**	**Mail Order 90-Day Supply[1]**
Generic Drugs	$20 (no change)	$40 (was $41)	$15 (no change)	$35 (no change)
Preferred Brand-Name Drugs (Formulary)	$40 (was $30)	$90 (was $78)	$30 (was $25)	$70 (was $65)
Non-Preferred Brand-Name Drugs (Non-Formulary)	$80 (was $45)	$160 (was $125)	$60 (was $40)	$165 (was $110)
Specialty Drugs[2]	$60 (was $30)	$120 (was $78)	$45 (was $25)	$105 (was $65)

[1]You will pay the same mail order copayment regardless of whether the quantity is 90 days or a lesser amount.
[2]Without regard to Preferred or Non-Preferred Brand-Name Drugs.

In addition, the Omnipod 5 Insulin Delivery System and insulin pods can now be obtained through the prescription plan.

If you have any questions, please contact Express Scripts customer service at 800.818.0883.

Sincerely,

Trustees of the Pension, Hospitalization and Benefit Plan of the Electrical Industry

Summary of Material Modifications
This notice is considered a Summary of Material Modifications under the Employee Retirement Income Security Act of 1974 (ERISA). You should keep this with your Summary Plan Description.

Express Scripts manages your prescription plan for the Pension, Hospitalization and Benefit Plan 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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan does not have a deductible.
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, 2023 $9,100 individual / $18,200 family, 2024 $9,450 individual/ $18,900 family. The overall out-of-pocket limits do 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 provided by Network providers. 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 an out-of-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.

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	$35 copay/visit	$50 copayment applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical. $25 copayment for acute care visits to JIB Medical, PC.
	Specialist visit	$50 copay/visit	$50 copay/visit	$65 copayment applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical. $25 copayment for acute care visits to JIB Medical, PC. 30-visit limit for Chiropractor. Acupuncture covered only if provided at JIB Medical, PC.
	Preventive care/screening/ immunization	None	$35 copay/visit	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.
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay/test	$35 copay/test	When required by law, non-Network diagnostic tests and imaging will be covered as Network. $25 copayment for x-rays related to an acute care visit at JIB Medical, PC. No copayment for blood work at JIB Medical, PC.
	Imaging (CT/PET scans, MRIs)	$100 copay/test	$100 copay/test	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs (including Specialty drugs)	For active Participants: $20 retail (up to 34-day supply) or $41 mail order (90-day supply)/ prescription. For retired Participants: $15 retail (up to 34-day supply) or $35 mail order (90-day supply)/ prescription.	For active Participants: $20 retail (up to 34-day supply) or $41 mail order (90-day supply)/ prescription. For retired Participants: $15 retail (up to 34-day supply) or $35 mail order (90-day supply)/ prescription.	You pay the difference between the cost of the non-generic and the generic equivalent, if available. Maintenance medication must be filled via Mail Order after one original fill and one refill at a local pharmacy. 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 on what Specialty drugs are covered under the SaveOn Program, contact a SaveOn representative at (800) 683-1704. You will pay the same mail order copayment regardless of whether the quantity is 90 days or a lesser amount.
	Preferred brand drugs (including Specialty drugs)	For active Participants: $30 retail (up to 34-day supply) or $78 mail order (90-day supply) /prescription. For retired Participants: $25 retail (up to 34-day supply) or $65 mail order (90-day supply) /prescription.	For active Participants: $30 retail (up to 34-day supply) or $78 mail order (90-day supply) /prescription. For retired Participants: $25 retail (up to 34-day supply) or $65 mail order (90-day supply) /prescription.	
	Non-preferred brand drugs (including Specialty drugs)	For active Participants: $45 retail (up to 34-day supply) or $125 mail order (90-day supply) /prescription. For retired Participants: $40 retail (up to 34-day supply) or $110 mail order (90-day supply) /prescription.	For active Participants: $45 retail (up to 34-day supply) or $125 mail order (90-day supply) /prescription. For retired Participants: $40 retail (up to 34-day supply) or $110 mail order (90-day supply) /prescription.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	$100 copay	Service must be preauthorized by plan or coverage could be lost. Copayments apply to certain ancillary services; including but not limited to advanced radiology, x-ray, laboratory and pathology.

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)	
	Physician/surgeon fees	$500 copay/procedure	$500 copay/procedure with a $1,000 out-of-pocket limit for any surgical procedure.	Service must be preauthorized by plan or coverage could be lost. $500 copayment is not included in $1,000 out-of-pocket cap per surgical procedure applicable to non-Network providers. 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	
	Urgent care	$75 copay/visit	$75 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission plus $200 per day with a $1,000 out-of-pocket limit for hospital room and board charges.	$500 copay per admission plus $200 per day with a $1,000 out-of-pocket limit for hospital room and board charges.	Service must be preauthorized by plan in order for it to be covered. or coverage could be lost. Copayments apply to certain ancillary services, including but not limited to advanced radiology, x-ray, laboratory and pathology, and are not included in the $1,000 out-of-pocket cap per hospital admission.
	Physician/surgeon fees	$50 for Specialist visits $500 copay/procedure for surgeon	$50 for Specialist visits $500 copay/procedure for surgeon with a $1,000 out-of-pocket limit for any surgical procedure.	Service must be preauthorized by plan or coverage could be lost. $500 copayment is not included in the $1,000 out-of-pocket cap per surgical procedure applicable to non-Network providers. When required by law, non-Network physician and surgeon fees will be covered as Network.

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 mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit	$35 copay/visit	$50 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 per admission plus $200 per day with a $1,000 out-of-pocket limit for hospital room and board charges.	$500 copay per admission plus $200 per day with a $1,000 out-of-pocket limit for hospital room and board charges.	Must be preauthorized by the plan or coverage could be lost. There is no copayment for elective inpatient substance abuse rehabilitation. Copayments apply to certain ancillary services, including but not limited to specialist and laboratory services and are not included in the $1,000 out-of-pocket cap per hospital admission.
If you are pregnant	Office visits	$35 copay/visit	$35 copay/visit	Covers you or your spouse only, not dependent children. $50 copayment applies if you or your spouse has not obtained a physical exam.
	Childbirth/delivery professional services	$500 copay/delivery	$500 copay/delivery plus $1,000 out-of-pocket limit	Covers you or your spouse only, not dependent children. Depending on the type of services, a copayment 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.) Copayments apply to certain ancillary services, including but not limited to specialist and laboratory services.
	Childbirth/delivery facility services	$500 copay per admission plus $200 per day with a $1,000 out-of-pocket limit for hospital room and board charges.	$500 copay per admission plus $200 per day with a $1,000 out-of-pocket limit for hospital room and board charges.	

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	Service and number of visits must be preauthorized by the plan or coverage could be lost. $50 copayment applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical. *Occupational and physical therapy not covered unless expected to restore maximum level of function lost due to disease or injury. Speech therapy is covered only to recover a loss of existing speech function.
	Rehabilitation services*	$35 copay for first 4 out-patient visits	$35 copay for first 4 out-patient visits	
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	No charge	No charge	Service and number of visits must be preauthorized by the plan or coverage could be lost. **Omnipod 5 system insulin pods are covered by the prescription drug plan.
	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	Limit one exam every 12 months.
	Children's glasses	No charge	Not covered	Out-of-pocket expenses may be incurred for extra items. Must be provided through Jena Optical or, for Participants who are non-New York City residents or Nassau County residents, General Vision Services
	Children's dental check-up	Not covered	Not covered	Not covered

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 children of Participants who receive dependent coverage
- 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 up to 30 visits
- Emergency and Non-emergency care when traveling outside the U.S.
- Genetic testing
- Hearing aids
- Infertility treatment
- Routine eye care (Adult) through Jena Optical or, for Participants who are non-New York City residents or Nassau County residents, General Vision Services (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	$0
Specialist copayment	$35
Hospital copayment (3-day stay)	$1,000
Other copayments	$1,160

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,195
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,255**

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

The plan's overall deductible	$0
Specialist copayments	$100
Primary care copayment	$210
Other copayments	$1,800

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

Total Example Cost	**$5,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,110
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,230**

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

The plan's overall deductible	$0
Specialist copayments	$50
Emergency room copayment	$250
Other copayments	$320

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$620
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$620**

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