

# EMPLOYEES SECURITY FUND OF THE ELECTRICAL PRODUCTS INDUSTRIES

158-11 HARRY VAN ARSDALE JR. AVENUE, FLUSHING, N.Y. 11365 • TEL (718) 591-1100 • FAX (718) 591-2189 • [www.jibei.org](http://www.jibei.org)

Established 1944

HARRY VAN ARSDALE JR.  
Founder

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May 2021

## IMPORTANT NOTICE: TO ALL ACTIVE ESF PLAN 'C' ELIGIBLE PARTICIPANTS

### Enclosed please find the following:

- **Summary of Benefits and Coverage for the ESF:** The Patient Protection and Affordable Care Act ("PPACA") requires group health plans, such as the Employees Security Fund of the Electrical Products Industries Health and Welfare Plan ("ESF"), to furnish participants with a Summary of Benefits and Coverage or "SBC." The Summary of Benefits and Coverage is a 6-page summary of material provisions of a health plan in a uniform format.

This document summarizes the key features of the plan, such as covered benefits, cost-sharing provisions, and coverage limitations, coverage examples and exceptions and must conform to the PPACA's required language. **Please note that while such terms as "premiums," "co-insurance" and "deductibles" are required, they do not apply to your plan.**

- **Employees Security Fund Health and Welfare Plan Summary Material Modification Notice** advising participants that the Trustees amended the Plan to allow coverage of certain durable medical equipment to treat diabetes on a one-year trial basis.

For a more complete explanation of your plan's rules, covered benefits, cost-sharing provisions and exclusions, please refer to your Summary Plan Description, a copy of which can be found at [www.jibei.org](http://www.jibei.org).

**You or your health care provider may call the MagnaCare ESF dedicated line at 1-800-548-0138 with any questions or concerns.**

Sincerely,

Trustees of the Employees Security  
Fund of the Electrical Products  
Industries Health and Welfare Plan

### **“Grandfathered” Plan Status**

The Employees Security Fund of the Electrical Products Industries Health and Welfare Plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the Joint Industry Board of the Electrical Industry at 718-591-2000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.



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/> 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](http://www.dol.gov/ebsa/healthreform) and [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-718-591-2000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not Applicable	This <u>plan</u> does not have a <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.empireblue.com">www.empireblue.com</a> or call 844-243-5566 for a list of in-network hospitals effective 1/1/17. See <a href="http://www.magnacare.com">www.magnacare.com</a> or call 1-800-548-0138 for a list of in-network doctors and other providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). If you use an in-network doctor or other health care provider, this <u>plan</u> will pay some or all of the costs of covered services. Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services. Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [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)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> /visit	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> /visit	None
	<a href="#">Preventive care/screening/immunization</a>	\$50 <a href="#">copay</a> /visit; no copay for visits to JIB Medical, PC., Morristown Hospital or PEMG	\$50 <a href="#">copay</a> /visit	Plan pays for one annual diagnostic visit; injection treatment for allergies is not covered. 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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$30 copay/lab or pathology tests; \$50 copay/radiology, x-ray or ultrasound; \$75 copay/EKG, EEG, EMG	Not Covered	Allergy testing is not covered
	Imaging (CT/PET scans, MRIs)	\$100 copay/test	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs (including <a href="#">Specialty drugs</a> )	\$15 retail (up to 34-day supply) or \$45 mail order (90 day supply)/prescription	\$15 retail (up to 34-day supply) or \$45 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. <a href="#">Pre-approval</a> is required for some drugs or coverage could be lost.
	Preferred brand drugs (including <a href="#">Specialty drugs</a> )	\$25 retail (up to 34-day supply) or \$75 mail order (90 day supply)/prescription	\$25 retail (up to 34-day supply) or \$75 mail order (90 day supply)/prescription	
	Non-preferred brand drugs (including <a href="#">Specialty drugs</a> )	\$40 retail (up to 34-day supply) or \$120 mail order (90 day supply)/prescription	\$40 retail (up to 34-day supply) or \$120 mail order (90 day supply)/prescription	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 copay	Not covered	Must be <a href="#">pre-approved</a> by <a href="#">plan</a> or coverage could be lost
	Physician/surgeon fees	No charge	No Charge (but subject to balance billing, as with all	Must be <a href="#">pre-approved</a> by <a href="#">plan</a> or coverage could be lost; <a href="#">copayment</a> does not count

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least) copay/procedure	Out-of-Network Provider (You will pay the most) non-network providers)	
				toward <u>out-of-pocket limit</u> applicable to non- <u>Network providers</u> .
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	Limited to care provided by a hospital, surgicenter or other licensed medical facility due to an injury or other sudden illness for which any delay in obtaining medical care would seriously jeopardize the life or health of the individual; \$100 copay waived if admitted
	<a href="#">Emergency medical transportation</a>	\$100/trip	\$100/trip	None
	<a href="#">Urgent care</a>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$500 copay	Not covered	Service must be <u>pre-approved</u> by <u>plan</u> or coverage could be lost.
	Physician/surgeon fees	No charge	Not covered	Service must be <u>pre-approved</u> by <u>plan</u> or coverage could be lost.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	None
	Inpatient services	\$500 <u>copay</u> ; no <u>copay</u> for inpatient substance abuse rehabilitation	Not covered	Must be <u>pre-approved</u> by the <u>plan</u> or coverage could be lost.
<b>If you are pregnant</b>	Office visits	\$50 <u>copay</u> /visit	Not covered	Covers Participant or Participant's spouse only, not dependent children. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Facility services must be pre-approved by the plan or coverage could be lost.
	Childbirth/delivery professional services	\$50 copay for first office visit; No Charge thereafter	Not covered	
	Childbirth/delivery facility services	\$500 <u>copay</u> /delivery	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	No charge	Covered only if immediately following a hospital admission and only if <u>pre-approved</u> by <u>plan</u> for diagnosis of cancer, otherwise coverage could be lost.
	<a href="#">Rehabilitation services</a>	No charge	Not covered	Inpatient coverage only, and only if

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				immediately following a hospital admission; limited to 15 days per incident, 45 days per year; must be <u>pre-approved by plan</u> or coverage could be lost.
	<a href="#">Habilitation services</a>	Not covered	Not covered	Excluded service
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	Excluded service.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	Limited to oxygen for cancer diagnosis.
	<a href="#">Hospice services</a>	Not covered outpatient; \$500 <u>copay</u> for inpatient	Not covered	Inpatient facility must be <u>pre-approved by plan</u> or coverage could be lost.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	No charge	Limit one exam every 12 months.
	Children's glasses	No charge	No charge	Limit one exam every 12 months.
	Children's dental check-up	No charge	No charge	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](#).)**

- Acupuncture
- Allergy testing and injection treatment
- Bariatric surgery unless it is deemed to be medically necessary by the Plan
- Chiropractic care
- Cosmetic surgery except treatment of accidental injuries sustained by a covered individual if the surgery begins within 90 days of accident or reconstructive surgery necessitated by major surgery
- Durable medical equipment
- Habilitation services
- Hearing aids
- Infertility treatment
- Gene therapy treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Skilled nursing care
- Weight loss programs

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

- Dental care
- Emergency care when traveling outside the U.S.
- Private duty nursing, but only if immediately following a hospital admission and only if pre-certified by plan for diagnosis of cancer
- Routine eye care

**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](http://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](http://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 on how 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](#) \$50
- Hospital (facility) [copayment](#) \$500
- Other [copayment](#) \$650

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$1,260</b>
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**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 copayment](#) \$50
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$950

**This EXAMPLE event includes services like:**

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$800
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<b>The total Joe would pay is</b>	<b>\$1,800</b>
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**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$100
- Other [copayment](#) \$450

**This EXAMPLE event includes services like:**

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$200
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<b>The total Mia would pay is</b>	<b>\$800</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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December 22, 2020

## Important Information for all ESF Plan "C" Participants and their Eligible Dependents

### Diabetic Supply Coverage – One-Year Trial Period

Dear Participant:

The Trustees of the Employees Security Fund of the Electrical Products Industries Health and Welfare Plan ("ESF") have made a decision to amend the Plan's exclusion to allow for coverage of certain durable medical equipment (DME) to treat diabetes for a one-year trial period effective January 1, 2021 through December 31, 2021.

**Coverage of diabetic supplies will require pre-approval by MagnaCare's Medical Management Department and will only be covered when obtained by in-network providers.** When medically necessary, eligible participants may be covered for the following diabetic supplies:

- Blood sugar monitors, blood sugar test strips, lancet devices, lancets, and glucose control solutions for participants with diabetes, whether or not they use insulin.
- Insulin pumps and pump supplies (insulin used in the pump will continue to be covered by Express Scripts, Inc.) for participants with diabetes who meet certain requirements. Check with MagnaCare to see if you meet the requirements.
- Participants with diabetes who use insulin may be able to get up to 300 test strips and 300 lancets every three months. Participants with diabetes who don't use insulin may be able to get up to 100 test strips and 100 lancets every three months. If your doctor says it is medically necessary, you can get additional quantities of testing supplies. Additional documentation is required.
- Continuous glucose monitors (CGM) that are classified as "therapeutic CGMs." There are specific criteria a participant must meet in order to be eligible for coverage for therapeutic CGMs and associated supplies. Check with your health care provider and MagnaCare to see if you qualify.

**You or your health care provider may call the MagnaCare ESF dedicated line at 1-800-548-0138 with any questions or concerns.**

Sincerely,

Trustees of the Employees Security Fund  
of the Electrical Products Industries  
Health and Welfare Plan

### **“Grandfathered” Plan Status**

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