

# EMPLOYEES SECURITY FUND OF THE ELECTRICAL PRODUCTS INDUSTRIES

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Established 1944

HARRY VAN ARSDALE JR.  
Founder

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## IMPORTANT NOTICE: TO ALL ACTIVE ESF PLAN 'A' 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.**

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.jibe.org](http://www.jibe.org).

**You or your health care provider may call the MagnaCare ESF dedicated line at 1-800-352-6465 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.jibe.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 overall <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 1-800-352-6465 for a list of in-network doctors and other providers.	This <u>plan</u> uses a <u>provider network</u> for certain services. 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> . However, the <u>plan</u> only covers specialists for maternity, surgery or wellness exams.

 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)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	Not covered	Not covered	Excluded service
	<a href="#">Specialist</a> visit	No charge	No charge	<a href="#">Plan</a> only covers specialist visits for maternity, surgery, or annual wellness exams. Paid at <a href="#">network</a> fee schedule.
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Limited to one annual diagnostic or routine gynecological visit. No <a href="#">copayment</a> for visits to JIB Medical, PC., Morristown Hospital or PEMG. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Immunization only covered to age 18.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge	Only covered where included in hospital bill for hospital-based procedures or where tests are performed in conjunction with pregnancy at a free-standing facility, or when included as part of an annual diagnostic exam or for diagnosis of cancer. Paid at <a href="#">network</a> fee schedule.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Only covered where included in hospital bill for hospital-based procedures or where tests are performed in conjunction with pregnancy at a free-standing facility or for diagnosis of cancer. Paid at <a href="#">network</a> fee schedule.
If you need drugs to treat your illness or	Generic drugs (including <a href="#">Specialty drugs</a> )	\$15 retail (up to 34-day supply) or \$45 mail	\$15 retail (up to 34-day supply) or \$45 mail order	You pay the difference between the cost of the non-generic and the generic equivalent,

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>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>		order (90-day supply)/prescription	(90-day supply)/prescription	if available. Maintenance medication must be filled via Mail Order after one original fill and one refill at a local pharmacy. <u>Pre-authorization</u> 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)	No charge, unless fee exceeds \$400/day plan limit	No charge, unless fee exceeds \$400/day plan limit	Limited to \$400 per day for both <u>network</u> and <u>out-of-network providers</u> .
	Physician/surgeon fees	\$1,000 <u>copayment/procedure</u>	\$1,000 <u>copayment/procedure</u>	There is a \$1,000 annual cap on surgical copayments. \$1,000 is the most you pay annually for covered <u>network</u> surgeon fees. Covers one pre-surgical consultation visit per year.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No charge, unless fee exceeds \$400/day <u>plan</u> limit	No charge, unless fee exceeds \$400/day <u>plan</u> limit	Emergency room services are only covered if patient is admitted to the hospital through the emergency room. Limited to \$400 per day for both <u>network</u> and <u>out-of-network providers</u> .
	<a href="#">Emergency medical transportation</a>	Not covered	Not covered	Excluded service
	<a href="#">Urgent care</a>	Not covered	Not covered	Excluded service
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,000 <u>copayment/admission</u>	\$1,000 <u>copayment/admission</u>	Limited to \$400 per day for both <u>network</u> and <u>out-of-network providers</u> .
	Physician/surgeon fees	\$1,000 <u>copayment/procedure</u>	\$1,000 <u>copayment/procedure</u>	Anesthesia benefit is 100% of <u>network</u> fee schedule. There is a \$1,000 annual cap on surgical <u>copayments</u> . \$1,000 is the most

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)	
				you pay annually for covered <u>network</u> surgeon fees.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Limited to one annual diagnostic psychiatric or substance abuse office visit. No coverage for outpatient hospital services.
	Inpatient services	\$1,000 <u>copayment</u> / admission	\$1,000 <u>copayment</u> / admission	Limited to \$400 per day for both <u>network</u> and <u>out-of-network</u> providers. There is no <u>copayment</u> for inpatient substance abuse rehabilitation.
If you are pregnant	Office visits	No charge when part of global services	No charge when part of global services	Covers Participant or Participant's spouse only, not dependent children. <u>Plan</u> pays up to \$400 per day for facility. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$1,000 <u>copayment</u>	\$1,000 <u>copayment</u>	
	Childbirth/delivery facility services	\$1,000 <u>copayment</u>	\$1,000 <u>copayment</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	No charge	Covered only if immediately following a hospital admission for diagnosis of cancer. Paid at <u>network</u> fee schedule.
	<a href="#">Rehabilitation services</a>	Not covered	Not covered	Excluded service
	<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>	Not covered	Not covered	Excluded service
	<a href="#">Hospice services</a>	Not covered	Not covered	Excluded service
If your child needs dental or eye care	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
- Diagnostic test, other than where included in hospital, pregnancy, or annual exam
- Durable medical equipment
- Emergency room care, other than with hospital admission.
- Emergency medical transportation
- Gene therapy treatment
- Habilitation services
- Hearing Aids
- Home health care
- Hospice service
- Imaging, other than where included in hospital, pregnancy, or annual exam
- Infertility treatment
- Long-term care
- Mental/behavioral outpatient services
- Non- Emergency care when traveling outside the U.S.
- Primary care visit to treat an injury or illness
- Private-duty nursing
- Rehabilitation services
- Routine foot care
- Skilled nursing care
- Specialist visit, other than for maternity, surgery, or wellness exams
- Substance use disorder outpatient services
- Urgent 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
- Routine eye care, limited to one exam per year

**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? No

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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$1000
■ Hospital (facility) <a href="#">copayment</a>	\$1000
■ Other <a href="#">copayment</a>	\$0

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>\$21,625</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$2,135
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$900
<b>The total Peg would pay is</b>	<b>\$14,635</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$1000
■ Other <a href="#">copayment</a>	\$15

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>\$8,840</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$360
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$5,240
<b>The total Joe would pay is</b>	<b>\$5,600</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$0

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>\$4,745</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,745
<b>The total Mia would pay is</b>	<b>\$4,745</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.