EMPLOYEES SECURITY FUND
OF THE ELECTRICAL PRODUCTS INDUSTRIES
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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 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. You can use this summary in the event that you need to find other comparative insurance. **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 continue to allow coverage of certain durable medical equipment to treat diabetes for an additional one-year period.**

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.

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. 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 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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses
Will you pay less if you use a network provider?	Yes. **See www.empireblue.com or call 844-243-5566** for a list of in-network hospitals effective 1/1/17. See **www.magnacare.com or call 1-800-352-6465** for a list of in-network doctors and other 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 out-of-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). If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware your network provider might use an out-of-network provider for some services. 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 **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 provider's office or clinic	Primary care visit to treat an injury or illness	$50 copayment/visit	$50 copayment/visit	None
	Specialist visit	$50 copayment/visit	$50 copayment/visit	None
	Preventive care/screening/ immunization	$50 copayment/visit; no copayment for visits to JIB Medical, PC., Morristown Hospital or PEMG	$50 copayment/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.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copayment/lab or pathology tests; $50 copayment/radiology, x-ray or ultrasound; $75 copayment/EKG, EEG, EMG	Not Covered	Allergy testing is not covered. When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	$100 copayment/test	Not Covered	When required by law, out-of-network imaging will be treated as in-network.
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)	$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. Pre-approval is required for some drugs or coverage could be lost.
	Preferred brand drugs (including Specialty drugs)	$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 Specialty drugs)	$40 retail (up to 34-day supply) or $120 mail order (90-day	$40 retail (up to 34-day supply) or $120 mail order (90-day	

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)	
		supply)/prescription	supply)/prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copayment	Not covered	Must be pre-approved by plan or coverage could be lost.
	Physician/surgeon fees	No charge copayment/procedure	No Charge (but subject to balance billing if permitted under law, as with all non-network providers)	Must be pre-approved by plan or coverage could be lost. When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need immediate medical attention	Emergency room care	$100 copayment/visit	$100 copayment/visit	$100 copayment waived if admitted.
	Emergency medical transportation	$100/trip	$100/trip	None
	Urgent care	$50 copayment/visit	$50 copayment/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment	Not covered	Service must be pre-approved by plan or coverage could be lost.
	Physician/surgeon fees	No charge	Not covered	Service must be pre-approved by plan or coverage could be lost. When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copayment/visit	$50 copayment/visit	None
	Inpatient services	$500 copayment; no copayment for inpatient substance abuse rehabilitation	Not covered	Must be pre-approved by the plan or coverage could be lost.
If you are pregnant	Office visits	$50 copayment/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
	Childbirth/delivery professional services	$50 copayment for first office visit; No Charge thereafter	Not covered	
	Childbirth/delivery facility	$500	Not covered	

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)	
	services	copayment/delivery		(i.e., ultrasound.) Facility services must be pre-approved by the plan or coverage could be lost.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Covered only if immediately following a hospital admission and only if pre-approved by plan for diagnosis of cancer, otherwise coverage could be lost.
	Rehabilitation services	No charge	Not covered	Inpatient coverage only, and only if immediately following a hospital admission; limited to 15 days per incident, 45 days per year; must be pre-approved by plan or coverage could be lost.
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	Not covered	Not covered	Excluded service
	Durable medical equipment	No charge	Not covered	Limited to oxygen for cancer diagnosis.
	Hospice services	Not covered outpatient; $500 copayment for inpatient	Not covered	Inpatient facility must be pre-approved by plan or coverage could be lost.
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 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. 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 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.

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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$800
The total Joe would pay is	**$1,800**

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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Mia would pay is	**$800**

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