EMPLOYEES SECURITY FUND
OF THE ELECTRICAL PRODUCTS INDUSTRIES

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Dear Participant:

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 an 8-page summary of material provisions of a health plan in a uniform format.

Enclosed please find the Summary of Benefits and Coverage for the ESF. 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.jibei.org.

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

Sincerely,

The Joint Industry Board of the Electrical Industry

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

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013-12/31/2013
Coverage for: Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.jibei.org/ee_secur_fund_med_plan.asp or by calling 1-718-591-2000

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 0	See the chart on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out–of–pocket limit**.	Not applicable because there's no **out–of–pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	Yes. **$2,000,000** for the Participant and separately for each eligible dependent.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on number of office visits.
Does this plan use a network of providers?	Yes. See www.magnacare.com or call 1-877-624-6210 for a list of in-network providers.	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 in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use In-Network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay/visit	$50 copay/visit	No copay for JIB Medical Department visits
	Specialist visit	$50 copay/visit	$50 copay/visit	No copay for JIB Medical Department visits
	Other practitioner office visit	Not Covered	Not Covered	Excluded Service
	Preventive care/screening/immunization	No Charge	Not Covered	Up to one annual diagnostic visit; Visits are paid at 100% when rendered at the Joint Industry Board Medical Center, Morristown Hospital or PEMG; Diagnostic visits rendered at other facilities or by other providers will be paid at a maximum of $125 for patients over the age of 14 and a maximum of $60 for patients under the age of 14
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay/lab or pathology test;$50 copay/radiology, x-ray or ultrasound; $75 copay/EKG, EEG,EMG	Not Covered	No copay for JIB Medical Department visits
	Imaging (CT/PET scans, MRIs)	$100 copay/test	Not Covered	–none--

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medco.com	Generic 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. Prior authorization is required for some drugs or coverage could be lost. Effective January 1, 2013 there is an annual family maximum of $5,000 for all prescription drug benefits.
	Preferred brand 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	$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.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay	Not Covered	Must be pre-certified by plan or coverage could be lost.
	Physician/surgeon fees	No Charge copay/procedure	No Charge (but subject to balance billing, as with all non-network providers)	Must be pre-certified by plan or coverage could be lost
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Service must be approved by plan within 24 hours or coverage could be lost; $100 co-pay waived if admitted
	Emergency medical transportation	$100/trip	$100/trip	
	Urgent care	No Charge.	No Charge.	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay	Not Covered	Must be pre-certified by Plan or coverage could be lost
	Physician/surgeon fee	No Charge	Not Covered	--none--

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay/visit	$50 copay/visit	–none--
	Mental/Behavioral health inpatient services	$500 copay	Not Covered.	Must be pre-certified through Members Assistance Program or coverage could be lost
	Substance use disorder outpatient services	$50 copay/visit	50 copay/visit	–none--
	Substance use disorder inpatient services	No Charge	Not Covered	Must be pre-certified through Members Assistance Program or coverage could be lost
If you are pregnant	Prenatal and postnatal care	$50 copay for first office visit; No Charge thereafter	Not Covered	Covers Participant or Participant's spouse only, not dependent children.
	Delivery and all inpatient services	$500 copay	Not Covered	Must be pre-certified by 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-certified by plan for diagnosis of cancer, otherwise coverage could be lost
	Rehabilitation services	No Charge	Not Covered	Covered only if immediately following a hospital admission; limited to 15 days per incident, 45 days per year; inpatient must be pre-certified by plan if with prior admission to hospital 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 service	Not covered outpatient; $500 copay for inpatient	Not Covered	Inpatient facility must be pre-certified by plan or coverage could be lost

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Exam reimbursed up to $35	Limit one visit every 12 months See page 6 for coverage imitations
	Glasses	No Charge	Single vision lenses & frames: $ 45 Bi-focal lenses & frames: $ 85	Limit once every 12 months
	Dental check-up	No Charge	No Charge	Participants are covered up to a $1500 annual maximum

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery unless it is deemed to be medically necessary by the Plan
- Charges by an optician
- 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
- Genetic testing
- Habilitation services
- Hearing Aids
- Infertility treatment
- Long-term care
- Routine foot care
- Skilled nursing care
- Substance use disorder outpatient services
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Dental care (adult)
- Emergency care when travelling 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 (adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal law may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (718) 591-2000, ext. 2491. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Joint Industry Board of the Electrical Industry, (718) 591-2000. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,450
- **Patient pays**: $1,090

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

***Patient pays:**

Deductibles	$0
Co-pays	$940
Co-insurance	$0
Limits or exclusions	$150
Total	**$1,090**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $ $1,510
- **Patient pays** $2,590

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

***Patient pays:**

Deductibles	$0
Co-pays	$1,240
Co-insurance	$0
Limits or exclusions	$1,350
Total	**$2,590**

These examples are based upon the patient using in-network providers and do not necessarily reflect benefits actually covered by the Plan.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copays**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copays**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.