// EMPLOYEES SECURITY FUND
OF THE ELECTRICAL PRODUCTS INDUSTRIES
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December 2012

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 A:

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. A **$2,000,000** annual limit applies to 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 the 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?	This plan does not cover specialists	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6 See your policy or plan document for additional information about **excluded services**.

Employees' Security Fund of the Electrical Products Industries Health and Welfare Plan – Plan A:

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

- **Copays** 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 **coinsurance** 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 a 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	No Charge	No Charge	Only covers one pre-surgical consultation visit per year.
	Specialist visit	Not Covered	Not Covered	Excluded Benefit
	Other practitioner office visit	Not Covered	Not Covered	Excluded Benefit
	Preventive care/screening/ immunization	No Charge	No Charge	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)	No Charge	No Charge	Only covered where included in hospital bill for hospital-based

Questions: Call (718) 591-2000 or visit us at www.jibei.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call (718) 591-2000 to request a copy.

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
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	
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. 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)	$1,000 copay/admission	$1,000 copay/admission	Limited to $400 per day for up to 120 calendar days per year.
	Physician/surgeon fees	$1,000 copay/procedure	$1,000 copay/procedure	Limited to $400 per procedure; copays capped at $1,000 per year; anesthesia benefit is 100% of network fee schedule.
If you need immediate medical attention	Emergency room services	$1,000 copay/visit	$1,000 copay/visit	Emergency Room is only covered if patient is admitted to hospital through the emergency room. Limited to $400 per procedure
	Emergency medical transportation	Not Covered	Not Covered	Excluded Benefit
	Urgent care	$1,000 copay/visit	$1,000 copay/visit	Limited to $400 per procedure

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 a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay/admission	$1,000 copay/admission	Limited to $400 per day up to a maximum of 120 days per calendar year.
	Physician/surgeon fee	$1,000 copay/procedure	$1,000 copay/procedure	Copays capped at $1,000 per year. Anesthesia benefit is 100% of network fee schedule.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	Excluded Benefit
	Mental/Behavioral health inpatient services	$1,000 copay/admission	$1,000 copay/admission	Plan pays up to $400 per day. Up to a maximum of 120 days per calendar year
	Substance use disorder outpatient services	Not Covered	Not Covered	Excluded Benefit
	Substance use disorder inpatient services	$0 copay	$1,000 copay/admission	In-network applies to MAP-approved facility. Non-network benefit limited to $400 per day up to a maximum of 120 days per calendar year.
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	$1,000 copay	$1,000 copay	

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Non-Network Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Limited to participants with cancer diagnosis. Must be preauthorized by MagnaCare.
	Rehabilitation services	Not Covered	Not Covered	Excluded Benefit
	Habilitation services	Not Covered	Not Covered	Excluded Benefit
	Skilled nursing care	Not Covered	Not Covered	Excluded Benefit
	Durable medical equipment	Not Covered	Not Covered	Excluded Benefit
	Hospice service	Not Covered	Not Covered	Excluded Benefit
If your child needs dental or eye care	Eye exam	$0	Exam reimbursed up to $35	Limit one visit every 12 months.
	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
- Chiropractic care
- Cosmetic surgery
- Durable medical equipment
- Emergency medical transportation
- Genetic testing
- Habilitation services
- Hearing aids
- Hospice service
- Infertility treatment
- Long-term care
- Mental/Behavioral health outpatient services
- Non-emergency care when travelling outside the U.S.
- Private Duty Nursing
- Rehabilitation services
- Routine foot care
- Skilled Nursing Care
- Specialist visit
- 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)
- 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:** $6,370
- **Patient pays**: $1,170

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	$1,020
Co-insurance	$0
Limits or exclusions	$150
Total	**$1,170**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $ $2,150
- **Patient pays** $1,950

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	$600
Co-insurance	$0
Limits or exclusions	$1,350
Total	**$1,950**

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.