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 http://jibei.org/ee_secur_fund_med_plan.asp 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 1-800-548-0138** 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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 copay/visit	$50 copay/visit	None
	Specialist visit	$50 copay/visit	$50 copay/visit	None
	Preventive care/screening/ immunization	$50 copay/visit; no copay for visits to JIB Medical, PC., Morristown Hospital or PEMG	$50 copay/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 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
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 supply)/prescription	$40 retail (up to 34-day supply) or $120 mail order (90 day supply)/prescription	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay	Not covered	Must be pre-approved 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-approved by plan or coverage could be lost; copayment does not count toward out-of-pocket limit applicable to non-Network providers.
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Limited to care provided by a hospital, surgi-center 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
	Emergency medical transportation	$100/trip	$100/trip	None
	Urgent care	$50 copay/visit	$50 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay	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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/visit	$50 copay/visit	None
	Inpatient services	$500 copay; no copay 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 copay/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 copay/delivery	Not covered	

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 copay 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	Not 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
- Genetic testing
- Habilitation services
- Hearing aids
- Infertility 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 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 plan at 1-718-591-2000 or 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (*Ultrasounds) copayment*	$50
(Blood work) copayment	$30

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	$21,625

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,165
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$1,165

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*	$500
Other (prescription drugs) *copayment*	$15
(Blood work) copayment	$30

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	$8,840

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$620
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3740
The total Joe would pay is	$4360

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 *(Diagnostic test) copayment*	$50
(Blood work) copayment	$30

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	$4,745

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$185
Coinsurance	$0
What isn't covered	
Limits or exclusions	$630
The total Mia would pay is	$815

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

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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?	This plan has no overall out-of-pocket limit. There is an annual $1,000 cap on copayments for network surgeon fees.	This plan does not have an overall out-of-pocket limit on your expenses. The out-of-pocket limit on network surgeon fees is the most you could pay in a year for covered network surgeon fees.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an overall 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 1-800-548-0138 for a list of in-network doctors and other providers.	This plan uses a provider network for certain services. 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. However, the plan only covers specialists for maternity, surgery or wellness exams.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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	Not covered	Not covered	Excluded service
	Specialist visit	No charge	No charge	Plan only covers specialist visits for maternity, surgery, or annual wellness exams. Paid at network fee schedule.
	Preventive care/screening/ immunization	No charge	No charge	Limited to one annual diagnostic or routine gynecological visit. No copayment for visits to JIB Medical, PC., Morristown Hospital or PEMG. 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. Immunization only covered to age 18.
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 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 network 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 network fee schedule
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-authorization 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)	Non-Network Provider (You will pay the most)	
		supply)/prescription	supply)/prescription	
If you have outpatient surgery	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 Network and non-Network providers.
	Physician/surgeon fees	$1,000 copay/procedure	$1,000 copay/ procedure	Copayment does not count toward out-of-pocket limit applicable to non-Network providers. Covers one pre-surgical consultation visit per year.
If you need immediate medical attention	Emergency room care	No charge, unless fee exceeds $400/day plan limit	No charge, unless fee exceeds $400/day plan 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 Network and non-Network providers.
	Emergency medical transportation	Not covered	Not covered	Excluded service.
	Urgent care	Not covered	Not covered	Excluded service
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 for both Network and non-Network providers.
	Physician/surgeon fees	$1,000 copay/procedure	$1,000 copay/procedure	Copayment does not count toward out-of-pocket limit on Network providers; anesthesia benefit is 100% of network fee schedule. There is a $1,000 annual cap on Network surgical copayments.
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 copay/ admission	$1,000 copay/ admission	Limited to $400 per day for both Network and non-Network providers. There is no copayment for inpatient substance abuse rehabilitation. Copayment does not count toward out-of-pocket limit applicable to non-Network providers
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. Plan 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 copay	$1,000 copay	
	Childbirth/delivery facility services	$1,000 copay	$1,000 copay	
If you need help recovering or have	Home health care	No charge	No charge	Covered only if immediately following a hospital admission for diagnosis of cancer. Paid at network fee schedule

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
other special health needs	Rehabilitation services	Not covered	Not covered	Excluded service
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	Not covered	Not covered	Excluded service
	Durable medical equipment	Not covered	Not covered	Excluded service
	Hospice services	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
- Genetic testing
- 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.
- 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. 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 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 plan at 1-718-591-2000 or 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist Delivery *copayment*	$1000
Hospital (facility) *copayment*	$1000
Other (*Ultrasounds) copayment*	$00

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	$21,625

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,135
Coinsurance	$0
What isn't covered	
Limits or exclusions	$900
The total Peg would pay is	$14,635

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*	$0
Hospital (facility) *copayment*	$1000
Other (prescription drugs) *copayment*	$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)*

Total Example Cost	$8,840

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,240
The total Joe would pay is	$5,600

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *copayment*	$0
Hospital (facility) *copayment*	$0
Other *(Diagnostic test) copayment*	$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)*

Total Example Cost	$4,745

In this example, Mia would pay: $4,745 (This condition is not covered, so patient pays 100 percent)

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

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 http://jibei.org/ee_secur_fund_med_plan.asp 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 http://www.ddsinc.net/ or call 800-255-5681 for a list of network 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 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	Specialist visits are not covered, other than for some dental services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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	Not covered	Not covered	Excluded service
	Specialist visit	Not covered	Not covered	Excluded service
	Preventive care/screening/ immunization	No charge	No charge	Plan pays for one annual diagnostic visit. 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. Immunizations are only covered for dependents up to age 18.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Limited to those services provided as part of the annual diagnostic visit.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not covered	Excluded service
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 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	Not covered	Not covered	Excluded service

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	center)			
	Physician/surgeon fees	Not covered	Not covered	Excluded service.
If you need immediate medical attention	Emergency room care	Not Covered	Not covered	Excluded service
	Emergency medical transportation	Not covered	Not covered	Excluded service
	Urgent care	Not covered	Not covered	Excluded service
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Excluded service
	Physician/surgeon fees	Not covered	Not covered	Excluded service
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Excluded service
	Inpatient services	Not covered	Not covered	Excluded service
If you are pregnant	Office visits	Not covered	Not covered	Excluded service
	Childbirth/delivery professional services	Not covered	Not covered	Excluded service
	Childbirth/delivery facility services	Not covered	Not covered	Excluded service
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Excluded service
	Rehabilitation services	Not covered	Not covered	Excluded service
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	Not covered	Not covered	Excluded service.
	Durable medical equipment	Not covered	Not covered	Excluded service
	Hospice services	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
- Childbirth/delivery professional services
- Childbirth/delivery facility services
- Chiropractic care
- Cosmetic surgery
- Delivery and all inpatient services (pregnancy)
- Durable medical equipment
- Emergency room services
- Emergency medical transportation
- Genetic testing
- Habilitation services
- Hearing Aids
- Home health care
- Hospice services
- Hospital facility fee (e.g., hospital room)
- Hospital physician/surgeon fee
- Imaging (CT/PET scans, MRI's)
- Infertility treatment
- Long-term care
- Mental/behavioral health inpatient services
- Mental/ behavioral health outpatient services Non- Emergency care when traveling outside the U.S.
- Outpatient surgery facility fee (e.g., ambulatory surgery center)
- Outpatient surgery physician/surgeon fee
- Prenatal and postnatal office visits
- Preventive care/screening/immunizations, other than services provided under annual diagnostic visit benefit
- Primary care visit to treat an injury or illness
- Private duty nursing
- Rehabilitation services
- Routine foot care
- Skilled nursing care
- Specialist visit
- Substance use disorder inpatient services
- 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

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 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 plan at 1-718-591-2000 or 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 plan's overall deductible	$0
Specialist	$0
Hospital (facility)	$0
Other *(prescription drugs)* copayment	$15

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	$21,625

In this example, Peg would pay:

Cost Sharing	
Deductibles	$
Copayments	$135
Coinsurance	$
What isn't covered	
Limits or exclusions	$20,275
The total Peg would pay is	$20,410

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	$0
Hospital (facility)	$0
Other *(prescription drugs)* copayment	$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)*

Total Example Cost	$8,840

In this example, Joe would pay:

Cost Sharing	
Deductibles	$
Copayments	$360
Coinsurance	$
What isn't covered	
Limits or exclusions	$5,240
The total Joe would pay is	$5,600

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist	$0
Hospital (facility)	$0
Other	$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)*

Total Example Cost	$4,745

In this example, Mia would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$4,745
The total Mia would pay is	$4,745

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

NONDISCRIMINATION

Discrimination is Against the Law

The Employees Security Fund of the Electrical Products Industry (the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, call 718-591-2000 or write to: The Joint Industry Board, 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-718-591-2000.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1−718-591-2000。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-718-591-2000.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-718-591-2000.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-718-591-2000 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-718-591-2000.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט
1-718-591-2000

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-718-591-2000

UWAGA: Jezeli mówisz po polsku, mozesz skorzystac z bezplatnej pomocy jezykowej. Zadzwon pod numer 1-718-591-2000.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
1-718-591-2000

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-718-591-2000.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-718-591-2000

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-718-591-2000.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-718-591-2000.

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-718-591-2000 まで、お電話にてご連絡ください

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-718-591-2000.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-718-591-2000.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-718-591-2000

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-718-591-2000 पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-718-591-2000

Summary Annual Report
for
Employees Security Fund of the Electrical Industry Health and Welfare Plan

This is a summary of the annual report for Employees Security Fund of the Elec Industry Health and Welfare Plan, 13-6100908/501 for January 1, 2016 through December 31, 2016. The annual report has been filed with the Employee Benefits Security Administration, formerly known as the Pension and Welfare Benefits Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $11,644,612 as of December 31, 2016, compared to $11,429,658 as of January 1, 2016. During the plan year the plan experienced a decrease in its net assets of $214,954. This decrease includes unrealized depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of $16,740,995, including employer contributions of $16,225,798, employee contributions of $55,118, gains of $134,408 from the sale of assets and earnings from investments of $325,671.

Plan expenses were $16,526,041. These expenses included $1,447,737 in administrative expenses and $15,078,304 in benefits paid to and/or earned by participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report;
2. Financial information and information on payments to service providers;
3. Assets held for investment;
4. Transactions in excess of 5% of plan assets;
5. Insurance information including sales commissions paid by insurance carriers;
6. Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103 - 12 investment entities in which the plan participates;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Joint Industry Board of the Electrical Industry, the Plan Administrator at 158-11 Harry Van Arsdale Jr. Avenue, Flushing NY 11365, (718) 591-2000.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, if any, or a statement of income and expenses of the plan and accompanying notes, if any, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes, if any, will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan at 158-11 Harry Van Arsdale Jr. Avenue, Flushing NY 11365 and at the US Department of Labor in Washington DC, or obtain a copy from the US Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue, NW, Washington DC 20210.