

**EMPLOYEES SECURITY FUND
OF THE ELECTRICAL PRODUCTS INDUSTRIES**

158-11 HARRY VAN ARSDALE JR. AVENUE • FLUSHING, N.Y. 11365
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December 2025

Established 1944
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Founder

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**IMPORTANT NOTICE:
TO ALL ACTIVE ESF PLAN 'C' ELIGIBLE PARTICIPANTS**

Dear Participant:

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 SBC 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 for the coverage period beginning on January 1, 2026. We recommend you retain a copy of the SBC with your other ESF records.

Please note that while such terms as "premiums," "co-insurance" and "deductibles" are required by federal regulations to appear in the SBC, they do not apply to your plan.

- **Important Notice Informing Individuals About Nondiscrimination and Accessibility Requirement Applicable to Employees Security Fund Health and Welfare Plan** advising participants that the Plan does not discriminate on the basis of race, color, national origin, age, disability or sex.

For a more complete explanation of your Plan's rules, covered benefits, cost-sharing provisions and exclusions, please refer to your Summary Plan Description ("SPD") and SMMs, all 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.

**Important Notice Informing Individuals About Nondiscrimination and Accessibility
Requirements Applicable to the Employees Security Fund of the Electrical Products
Industries Health & Welfare Plan**

Discrimination is Against the Law

The Employees Security Fund of the Electrical Products Industries Health & Welfare Plan ("ESF") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). The ESF does not exclude people or treat them less favorably because of race, color, national origin, age or disability or sex.

The ESF:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator of the ESF.

If you believe that the ESF 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 grievance with: Civil Rights Coordinator, Employees Security Fund of the Electrical Products Industries Health & Welfare Plan, 158-11 Harry Van Arsdaale Jr. Avenue, Flushing, NY 11365, 718-591-2000, 718-380-7741, membersrecords@jibei.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

This notice is available on the ESF Health Plan page of the Joint Industry Board of the Electrical Industry's website: <https://www.jibei.org/>.



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 <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not Applicable	This <u>plan</u> does not have a <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.anthem.com or call 844-243-5566 for a list of in- <u>network</u> hospitals. See www.magnacare.com or call 1-800-548-0138 for a list of in- <u>network</u> doctors and other <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). If you use an in- <u>network</u> doctor or other health care <u>provider</u> , this <u>plan</u> will pay some or all of the costs of covered services. Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services. Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$50 <u>copay</u> /visit*	\$50 <u>copay</u> /visit	Telehealth services subject to a \$30 <u>copayment</u> . * \$25 <u>copay</u> /visit for non-preventative and sick care provided at JIB Medical P.C. See the December 2024 Summary of Material Modifications for more information.
	Specialist visit	\$75 <u>copay</u> /visit	\$75 <u>copay</u> /visit	If pre-surgical consultation with <u>specialist</u> , 1 visit/procedure limit.
	Preventive care/screening/immunization	\$50 <u>copay</u> /visit*	\$50 <u>copay</u> /visit	1 annual diagnostic or routine gynecological visit limit. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Immunization covered in- <u>network</u> only. * No charge when provided by JIB Medical, P.C.; Morristown Hospital or Professional Evaluation Medical Group (PEMG).

For more information about limitations and exceptions, see plan or policy document at <https://www.jibei.org/health/employees-security-fund-medical-prescription-drug-and-dental-plan/>.

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 have a test	Diagnostic test (x-ray, blood work)	\$45 <u>copay</u> /lab or pathology tests \$75 <u>copay</u> /radiology, x-ray or ultrasound \$115 <u>copay</u> /EKG, EEG, EMG	Not covered*	No coverage for allergy testing. * When required as a part of <u>emergency services</u> , will be treated as <u>in-network</u> .
	Imaging (CT/PET scans, MRIs)	\$155 <u>copay</u> /test	Not covered*	* When required as a part of <u>emergency services</u> , will be treated as <u>in-network</u> .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or by calling Express Scripts at (800) 818-0883 or Accredo Specialty at (800) 803-2523.	Generic drugs	\$20 retail/prescription* \$70 mail order/prescription**	\$20 retail/prescription* \$70 mail order/prescription**	You pay the difference between the cost of the non-generic and the generic equivalent, if available. You may make one fill and one refill for maintenance medication at an in-person pharmacy before they must be filled via Mail Order. <u>Preauthorization</u> is required for some drugs or coverage could be lost. * Up to a 34-day supply. ** Up to a 90-day supply. You will pay the same <u>copayment</u> regardless of whether the quantity is 90 days or a lesser amount.
	Preferred brand drugs (including Specialty drugs)	\$35 retail/prescription* \$115 mail order/prescription**	\$35 retail/prescription* \$115 mail order/prescription**	
	Non-preferred brand drugs	\$60 retail/prescription* \$185 mail order/prescription**	\$60 retail/prescription* \$185 mail order/prescription**	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$395 <u>copay</u> /procedure* \$155 <u>copay</u> /procedure**	Not covered***	Must be pre-approved by <u>plan</u> or coverage could be lost. * If performed at outpatient hospital ** If performed at ambulatory
	Physician/surgeon fees	No charge†	Not covered***	

For more information about limitations and exceptions, see plan or policy document at <https://www.jbei.org/health/employees-security-fund-medical-prescription-drug-and-dental-plan/>.

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)	
				<p>surgery center</p> <p>*** When required as a part of <u>emergency services</u>, will be treated as in-<u>network</u>.</p> <p>† \$155 <u>copay</u>/surgery applies if surgeon services were performed in office setting or surgical center.</p>
If you need immediate medical attention	Emergency room care	\$155 <u>copay</u> /visit	\$155 <u>copay</u> /visit	Waived if admitted.
	Emergency medical transportation	\$155 <u>copay</u> /trip	\$155 <u>copay</u> /trip	None.
	Urgent care	\$75 <u>copay</u> /visit	\$75 <u>copay</u> /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$790 <u>copay</u> /admission	Not covered*	<p>Must be pre-approved by <u>plan</u> or coverage could be lost.</p> <p>* When required as a part of <u>emergency services</u>, will be treated as in-<u>network</u>.</p>
	Physician/surgeon fees	No charge	Not covered*	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$75 <u>copay</u> /visit	No covered	None.
	Inpatient services	\$790 <u>copay</u> /visit*	Not covered**	<p>Must be pre-approved by the <u>plan</u> or coverage could be lost.</p> <p>* No <u>copay</u> for inpatient substance abuse rehabilitation at JIB Substance Abuse Services approved facility. For more information, call (718) 591-2000 ext. 1396.</p> <p>** When required as a part of <u>emergency services</u>, will be treated as in-<u>network</u>.</p>

For more information about limitations and exceptions, see plan or policy document at <https://www.jbei.org/health/employees-security-fund-medical-prescription-drug-and-dental-plan/>.

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 are pregnant	Office visits	\$50 <u>copay</u> /visit**	Not covered	<p>Dependent children not covered.</p> <p>Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)</p> <p>* Must be pre-approved by the <u>plan</u> or coverage could be lost unless the <u>plan</u> is notified of emergency situation.</p> <p>** Telehealth services subject to a \$30 <u>copayment</u>.</p>
	Childbirth/delivery professional services	\$50 <u>copay</u> for first office visit; no charge for service visits until childbirth/delivery	Not covered	
	Childbirth/delivery facility services*	\$790 <u>copay</u> /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 discharge and only if pre-approved by <u>plan</u> for diagnosis of cancer, otherwise coverage could be lost.
	Rehabilitation services	No charge	Not covered	Covered only if immediately following a hospital discharge. 15 days per incident limit. Must be pre-approved by <u>plan</u> or coverage could be lost.
	Habilitation services	Not covered	Not covered	<u>Excluded service</u>
	Skilled nursing care	Not covered	Not covered	
	Durable medical equipment	No charge	Not covered	Limited to oxygen for cancer diagnosis and diabetic supplies. Must be pre-approved by <u>plan</u> or coverage could be lost.

For more information about limitations and exceptions, see plan or policy document at <https://www.jibe.org/health/employees-security-fund-medical-prescription-drug-and-dental-plan/>.

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)	
	Hospice services	\$790 <u>copay</u>	Not covered	Inpatient coverage only. No coverage for outpatient services. Must be pre-approved by <u>plan</u> 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	
	Children's dental check-up	No charge	No charge	None

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your <u>policy</u> or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
<ul style="list-style-type: none"> Acupuncture Allergy testing and treatment Bariatric surgery, unless it is deemed to be <u>medically necessary</u> by <u>plan</u> Chiropractic care Cosmetic surgery except treatment of accidental injuries sustained by a covered individual if the surgery begins within 90 days of accident or <u>reconstructive surgery</u> necessitated by major surgery 	<ul style="list-style-type: none"> <u>Durable medical equipment</u>, unless for cancer diagnosis and diabetic supplies <u>Habilitation services</u> Hearing aids Infertility treatment Gene therapy treatment Long-term care Non-emergency care when traveling outside the U.S. Routine foot care <u>Skilled nursing care</u> 	<ul style="list-style-type: none"> Weight loss programs 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
<ul style="list-style-type: none"> Dental care (Adult) Emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private duty nursing, but only if immediately following a hospital admission and only if pre-approved by <u>plan</u> for diagnosis of cancer 	<ul style="list-style-type: none"> Routine eye care (Adult) 	

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. For more information about limitations and exceptions, see plan or policy document at <https://www.jibe.org/health/employees-security-fund-medical-prescription-drug-and-dental-plan/>.

[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
■ Primary care copayment	\$50
■ Hospital (facility) copayment	\$790
■ Other copayment	\$1,720

This EXAMPLE event includes services like:

[Primary care](#) 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$2,600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,600

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Primary care copayments	\$200
■ Prescription drugs copayment	\$560
■ Other copayment	\$180

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Joe would pay is	\$1,000

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$75
■ Emergency care copayment	\$155
■ Other copayment	\$75

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$600
The total Mia would pay is	\$900

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