IBEW LOCAL UNION 163
HEALTH & WELFARE and ANNUITY FUNDS

QUICK REFERENCE GUIDE

EFFECTIVE: JANUARY 1, 2025

Important Notice: This is an outline of the principal plan provisions of the I.B.E.W. Local Union 163 Welfare, and Annuity Plans and is not intended to completely describe the Plan provisions. In the event of any discrepancy between this outline and the Plans, the Plan Documents shall govern. For further information, please review your Summary Plan Description or contact the office of the Administrator, I. E. Shaffer & Co., at P. O. Box 1028, Trenton, NJ 08628. Telephone 1-800-792-3666.

IBEW LOCAL UNION 163 HEALTH & WELFARE FUND

ELIGIBILITY FOR ACTIVE PARTICIPANTS

Employment that entitles a member to become a Fund Participant is referred to as "Covered Employment." The eligibility of a Participant and his or her Covered Beneficiaries is determined based on the balances in the Participant's Dollar Bank and Benefit Credit Account. A member remains a Participant in the Fund until their Dollar Bank balance has been reduced to zero and they are no longer receiving benefits from the Fund by self-pay.

GENERAL RULES - ACTIVES

- The Participant will be credited one dollar for each dollar of contributions the Fund receives as a result of their Covered Employment.

- After initially becoming eligible for benefits, eligibility will continue from month to month only if the Participant has been credited with dollars of contributions equal to dollar hours of Covered Employment times the Fund's current hourly contribution rate.

- If the Participant has earned dollars of contributions in excess of 130 hours times the Fund's current hourly contribution rate during a Work Month, the amount of dollars in excess of the 130 hours will be credited to their Dollar Bank.

- The maximum amount of dollars that may accumulate in a Dollar Bank is 1,560 hours times the Fund's current hourly contribution rate.

- The dollars accrued in excess of the Dollar Bank maximum (1,560 hours times the Fund's current hourly contribution rate) will be allocated to the Participant's Benefit Credit Account. The Benefit Credit Account will be maintained to provide extended coverage, if needed.

- If a Participant is credited with less dollars of contributions than 130 hours of Covered Employment times the Fund's current hourly contribution rate, the dollars in their Dollar Bank will automatically be used to make up the difference between the number of dollars they were credited with and the dollars of contributions equal to 130 hours of Covered Employment times the Fund's current hourly contribution rate. In the event a Dollar Bank falls below the maximum (1,560 hours times the Fund's current hourly contribution rate), and the Participant has a balance in their Benefit Credit Account, the Benefit Credit Account

will be reduced in order to maintain the maximum amount of hours dollars in the Dollar Bank.

- The Benefit Credit Account is used to replenish the Dollar Bank and provide HRA benefits (Benefit Credit Account)

The number of hours of covered employment required for coverage is set by the Board of Trustees and requirements may be revised from time to time. Participants will be notified if the requirements are changed.

ELIGIBILITY & CONTRIBUTION RATE CALCULATION - ACTIVES

The contributions submitted by an employer for a Participant's work in Covered Employment are credited to their Dollar Bank, which is an account used to determine eligibility for benefits. A member remains a Participant in the Fund until their Dollar Bank balance has been reduced to zero and they are no longer receiving benefits from the Fund by self-pay. Contributions for all overtime hours worked shall be contributed at the applicable overtime rate.

Journeymen & All Other Classifications			
Effective Date	**Annuity Contribution Rate**	**Welfare Contribution Rate**	**Total Contribution Rate**
6/1/2023-5/31/2024	$9.83	$12.00	$21.83
6/1/2024-5/31/2025	$10.00	$12.00	$22.00

Total Reserve in Benefit Credit Account and Dollar Bank (Account Balance)	Formula #	Annuity Fund (AF) Contribution Rate Calculations	*6/1/24-5/31/25* Journeymen AF Contribution Rates	Welfare Fund (WF) Contribution Rate Calculations	*6/1/24-5/31/25* Journeymen WF Contribution Rates	*6/1/24-5/31/25* *Journeymen Total Contribution Rate*
Less than 3mo	Formula 1	AF rate minus 50%	$5.00	WF rate plus 50% of AF rate value	$17.00	$22.00
3mo – 2 years	Formula 2	Presumptive Rate	$10.00	Presumptive Rate	$12.00	$22.00
2 - 4 years	Formula 3	Increase 0%	$10.00	Decrease 0%	$12.00	$22.00
4 plus years	Formula 4	AF rate plus 50% of WF rate	$16.00	WF rate minus 50%	$6.00	$22.00

1st & 2nd Period Apprentices			
Effective Date	**Annuity Contribution Rate**	**Welfare Contribution Rate**	**Total Contributions**
6/1/2023-5/31/2024	$2.02	$12.00	$14.02
6/1/2024-5/31/2025	$2.19	$12.00	$14.19

The formulas will be applied as of the last day of each month. To the extent a change in contribution rates is required, the change shall apply beginning with hours worked on or after the first of the month following the month in which the change is determined to be required.

INITIAL ELIGIBILITY FOR BENEFITS - ACTIVES

- To satisfy the Initial Eligibility requirements for benefits, a Participant must have been credited with dollars of contributions equal to 400 hours of Covered Employment times the Fund's current hourly contribution rate.

- A Participant and their Covered Beneficiaries will be eligible to receive benefits on the first day of the month following the second month in which they have satisfied the Initial Eligibility requirements provided they are working or are available for work in Covered Employment on that day. *(See the table below for an illustration.)*

Table - Initial Eligibility for Benefits

If a Participant's Dollar Bank has dollars equal to 400 hours of covered employment times the Fund's hourly Welfare contribution rate	**A Participant may be eligible for benefits on the first day of:**
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

- Initial Eligibility shall cover a period of three (3) months.

- A Participant and their Covered Beneficiaries are not eligible for any benefits until the Participant meets the Initial Eligibility requirements and completes the enrollment forms provided by the Plan Administrator. If the initial enrollment form is not returned by the deadline, the Participant and their Covered Beneficiaries will not be enrolled until they submit an enrollment form.

- After initial enrollment, the election on file with the Plan Administrator will remain in effect until the Participant makes changes through Open Enrollment or when they have a Qualifying Special Event, as described below.

Open Enrollment Period
The open enrollment period is December 1 - December 31. To waive coverage, revoke a waiver, or add or drop Covered Beneficiaries, the Participant will need to complete and return the required forms to the Plan Administrator by the announced deadline. Your elections begin January 1.

Qualifying Special Events
There are only certain exceptions called Qualifying Special Events when a Participant is permitted to change their Covered Beneficiaries or revoke their waiver of benefits outside of Open Enrollment. Elections shall remain in effect until a Special Enrollment Period Form is submitted to the Plan Administrator along with the required supporting documentation. The following are Qualifying Special Events:

- Marriage or Birth
- Loss of Other Coverage (except Medicaid or a State Children's Health Insurance Program)
- Loss of Eligibility under Medicaid or a State Children's Health Insurance Program
- Eligibility for Medicaid or a State Children's Health Insurance Program

MAINTAINING BENEFIT ELIGIBILITY - ACTIVES

- A Participant will continue to receive benefits each month provided they are credited with dollars of contributions equal to 130 hours of Covered Employment times the Fund's current hourly contribution rate or they have a sufficient balance in their Dollar Bank to make up the difference.
- There is a three-month delay between the month in which a Participants actually earns coverage by working or by self-paying (their "Work Month") and the month in which their coverage is effective (your "Benefit Month"). The following chart shows how you maintain eligibility:

If a Participant is credited with dollars of contributions equal to 130 hours of covered employment times the Fund's hourly contribution rate:	A Participant may be eligible for benefits on the first day of:
January	May
February	June
March	July
April	August
May	September
June	October
July	November
August	December
September	January
October	February
November	March
December	April

- If contributions on behalf of a Participant are received for more than contributions equal to 130 hours of Covered Employment times the Fund's current hourly contribution rate, their Dollar Bank will be credited for the excess, which may be used for future eligibility.

- If contributions on behalf of a Participant are received for less than contributions equal to 130 hours of Covered Employment times the Fund's current hourly contribution rate, their Dollar Bank balance will automatically be applied to make up the difference in dollars.

- If their Dollar Bank balance is insufficient to cover the difference in dollars, the Participant may self-pay to maintain benefit eligibility as set forth below.

MAINTAINING BENEFIT ELIGIBILITY BY SELF-PAY - ACTIVES

- A Participant may elect to self-pay to maintain benefit eligibility when their Dollar Bank has an insufficient balance; however, self-pay is not permitted to satisfy the Initial Eligibility requirements.

- The self-pay contribution rate is $12 multiplied by the difference in hours required for eligibility. Payment must be received by the last business day of the month in which the notification was mailed to the participant.

- The Participant cannot maintain Benefit Eligibility by self-pay for more than 12 consecutive months.

- The Participant will be billed by mail for self-pay contributions. Payment must be made within the allowed time or coverage will terminate, and they will lose their right to have coverage continued through self-pay.

TRANSFER OF HOURS TO ANOTHER PARTICIPANT - ACTIVES

A Participant may give/transfer some or all of the dollars in their Dollar Bank to another Active Participant or Former Active Participant's Dollar Bank to allow them to maintain continuing eligibility. To do so, the Participant must complete and submit a form to the Fund's Plan Administrator in order to give/transfer the hours.

TERMINATION OF BENEFIT ELIGIBILITY -ACTIVES

- Eligibility for all Benefits will be terminated at the end of the Benefit Month if any one or more of the following events occur (status of Hour Dollar Bank shall be specified below):

    - Failure to make self-pay contributions, when eligible to do so, sufficient to meet the required dollar amount for the next Benefit Month, when the Participant's credited dollars are not sufficient to meet the prescribed dollars for the next Benefit Month. (Eligibility will terminate at the end of the Benefit Month. The Dollar Bank will remain in effect for 12 months for use for reinstatement.)

    - Commencement of work for an employer who is an electrical contractor who does not contribute to this Fund. (Coverage will terminate at the end of the Benefit Month, dollars in the Dollar Bank will be forfeited, and if the Participant returns to Covered Employment, they must requalify for benefits as described under the Initial Eligibility provisions.)

    - Failure of the Participant or Covered Beneficiary to submit all information required by the Fund, including but not limited to information regarding eligibility for benefits, employment status, circumstances surrounding the onset of illness or injury, other insurance coverage, receipt of benefits from any governmental agency, medical and hospital reports, records of employment, proof of date of birth, disability or death, or evidence of existence of marriage. (Coverage will terminate immediately, the Dollar Bank will be forfeited, the Participant will forfeit any extended coverage, and if they return to Covered Employment, they must requalify for benefits as described under the Initial Eligibility provisions.)

- Covered Beneficiaries shall lose eligibility for coverage (other than COBRA coverage) on the earliest of the following events:

    - A Participant ceases to be a Covered Participant under the Fund and their coverage terminates. Covered Beneficiaries will lose coverage when they do.

    - A dependent ceases to satisfy the Fund's definition of "Covered Beneficiary." Coverage will terminate at the end of the month in which the individual ceases to meet the definition of Covered Beneficiary, or on the date a Participant's coverage is terminated, whichever is earlier.

- When benefit eligibility terminates, the Participant or their Covered Beneficiaries may be eligible for continuation coverage of certain benefits.

ELIGIBILITY RULES – COVERED BENEFICIARIES

Participation in the Fund also makes a Covered Beneficiary eligible to receive benefits. Covered Beneficiaries are:

- A Participant's spouse:
    - A lawful spouse: the person to whom a Participant is legally married under applicable law.
    - A marriage certificate is required by the Plan Administrator to confirm spouse eligibility. Refusing to provide a marriage certificate to the Plan Administrator will result in a denial of spouse eligibility.

- A Participant's Child, less than 26 years of age:
    - Child includes a Participant's son, daughter, stepson or stepdaughter, legally adopted child, or one who has been lawfully placed with the Participant for legal adoption.
    - Child also includes an alternative recipient under a Qualified Medical Child Support Order (QMSCO). For more information about QMSCOs, please see Part VII Section A.
    - The Plan Administrator requires proof that an individual is a Participant's child. The proof shall include a copy of a birth certificate or court order/record, or any other documents deemed necessary by the Plan Administrator.

COBRA

If a Participant fails to satisfy the above requirements and lose eligibility, they and their qualified dependents may continue coverage under COBRA for up to 18 months (29 months if totally disabled). If their dependent loses eligibility due to a Participant's divorce or legal separation, or their dependent ceases to satisfy the definition of an eligible dependent, they may continue coverage under COBRA for up to 36 months.

Effective April 1, 2024, the monthly COBRA self-pay rates for Medical, RX, Dental and Vision under COBRA are:

Contract Type	Traditional COBRA	Disability 19-29 months
Single (Participant Only)	$812.55	$1,194.93
Participant + Spouse	$2,064.67	$3,036.29
Parent + Child(ren)	$1,643.97	$2,417.60
Family	$2,804.10	$4,123.68

REINSTATEMENT OF COVERAGE - ACTIVES

A former Active Participant's coverage will be reinstated when the former Active Participant is credited with dollars of contributions equal to 130 hours of Covered Employment times the Fund's current hourly contribution rate, provided this occurs within 12 months following the Work Month which previously resulted in the termination of eligibility of the Participant. A Participant whose coverage has been terminated for more than 12 months must satisfy the Initial Eligibility requirements set forth above before eligibility for benefits can be reinstated.

BENEFIT CREDIT ACCOUNT (BCA) - ACTIVES

Benefit Credit Account (BCA) Benefits are provided on a self-insured basis paid directly by the Fund and administered by the Plan Administrator. Quarterly statements shall be provided to you via mail, however, you may request your BCA balance at any time by calling the Fund Office.

ELIGIBLE ACTIVE PARTICIPANTS AND ELIGIBLE DEPENDENTS MAY USE THE BCA FOR:

- Qualified Medical Expenses - as defined and described in Section 213(d) of the IRS Code. https://www.irs.gov/publications/p502 and requested within 6 months from the date of service along with required reimbursement form and acceptable receipts.

- May use BCA for reimbursement of COBRA premiums (participant COBRA or qualified dependents)

- BCA benefits shall terminate once eligibility (active/self-pay/COBRA/retirees under 65) terminates or exhausts for the participant and/or qualified dependents.

COVERED DEPENDENT ELIGIBILITY UPON A PARTICIPANT'S DEATH

ACTIVE PARTICIPANTS:

- If a Participant is eligible for benefits and they were working in Covered Employment at the time of their death, their Covered Beneficiaries may continue to be covered until the Dollar Bank is exhausted. Once the Dollar Bank is exhausted, or if there are insufficient hours in the Dollar Bank, Covered Beneficiaries may maintain eligibility by making timely COBRA payments.

- Any extension of coverage to Covered Beneficiaries will be counted towards any additional coverage available under COBRA Continuation Coverage. *EXAMPLE:* If COBRA is available for 36 months and the participant has a month of coverage in the Dollar Bank available: 1 month coverage available from the Dollar Bank, 35 months COBRA premium due for a total of 36 months of coverage.

- Coverage for Covered Beneficiaries will terminate upon the earliest of the following events:

    - The date on which the Covered Beneficiary no longer meets the Fund's definition of a Covered Beneficiary.
    - The date the spouse remarries.
    - The date a Covered Beneficiary becomes covered by another group benefit plan.
    - COBRA Exhaustion

- Upon death of a retired or active member, the spouse may utilize the participant's Dollar Bank to continue coverage without having to self-pay.

- Participants covered by the Fund's Aetna group health plan, whether actively employed or COBRA, can use any BCA balance for HRA reimbursements. Anyone whose benefit eligibility is terminated loses coverage, Dollar Bank and BCA benefits.

PROCEDURES TO VOLUNTARILY WAIVE ELIGIBILITY FOR ALL BENEFITS - ACTIVES

- If a Participant has a Dollar Bank, they may elect, in writing, on a form to be provided by the Plan Administrator, to waive the use of their "banked" Dollars for maintaining continuing eligibility and have their eligibility for all benefits terminated. They must complete the Waiver of Benefits Form to do so.

- If they elect to waive eligibility for all benefits, they will no longer be eligible for any plan benefits provided by the Plan. These benefits include hospitalization, medical, surgical, disability, death, accidental death and dismemberment, prescription drug, vision care and dental care benefits.

- If they have a Benefit Credit Account, when they submit the election, the dollars in their Dollar Bank will be converted and placed in their Benefit Credit Account. They may use the Benefit Credit Account during the period when they have elected to freeze their eligibility for all benefits. When additional dollars are credited to their Bank, they will be added to their Benefit Credit Account, provided they have submitted proof to the Plan Administrator that they are covered under another Group Health Plan (such as through their spouse's employer) that meets the federal law requirements to be "integrated" with the Benefit Credit Account.

- Should they decide to revoke their election to waive eligibility for all benefits, a Participant may do so only during the Fund's Open Enrollment Period or if they have a Qualifying Special Event, as described above. If and when they submit a written revocation, the dollars in the Benefit Credit Account will be placed into their Dollar Bank, up to the maximum of 1,560 hours times the Fund's current hourly contribution rate.

- If they have a Qualifying Special Event, they must submit to the Fund's Plan Administrator a Special Enrollment Period Form within either 30 or 60 days of the Qualifying Special Event, along with the required supporting documentation. If the enrollment is not submitted within the required 30 or 60 days of the Qualifying Special Event, the reinstatement of all of their benefits will not be made until the next Open Enrollment Period.

ELIGIBILITY FOR RETIRED PARTICIPANTS

- You retire when you permanently leave Covered Employment or Industry Employment after attaining Early Retirement Age of 55 or Normal Retirement Age of 62 **AND** you are a Participant in the Fund on the annuity starting date of your National Electrical Benefit Fund (NEBF) pension (your "Retirement Date") **AND** have contacted the Fund Office, you will be eligible for the Fund's Post-Retirement Benefits.
- Participants are eligible to receive benefits from the Fund as of the annuity starting date of your National Electrical Benefit Fund (NEBF) pension, are not yet eligible to enroll in Medicare **AND** have contacted the Fund Office.
- On your retirement date, the Fund will establish a Retiree-Only HRA account for you. Your Retiree-Only HRA account's initial account a balance will be equal to the balance of your Benefit Credit Account as of the day before your retirement date. You may not make any contributions to your Retiree-Only HRA Account. Following retirement, Participants will be eligible for retiree coverage under the following provisions:

RETIREES AGE 55-64, NON-MEDICARE

- Your remaining Dollar Bank hours will be utilized to retain coverage in the Fund's Welfare Plan until the Dollar Bank is exhausted or you or your covered spouse become Medicare eligible (age 65 or awarded due to disability).
- Once your remaining Dollar Bank hours are exhausted, you may self-pay to retain coverage in the Fund's Welfare Plan until you or your covered spouse become Medicare eligible.
- Retirees and eligible dependents may continue to utilize available dollars in the Retiree-Only HRA for eligible expenses.

Retirees Under Age 65, Non-Medicare Self-Pay Rates
Effective April 1, 2024– March 31, 2025

Contract Type	Monthly Payment
Single (Retiree Only)	$812.55
Family	$2804.10

RETIREES OVER AGE 65 WITH MEDICARE

- Retirees over age 65 may continue to utilize available dollars in the Retiree-Only HRA for eligible expenses
- Retirees over age 65 may continue to self-pay for the retirement death benefit.
- Medical, RX, Vision and Dental benefits terminate the end of the month prior to the month of your Medicare eligibility.

Retirees Over 65, Medicare Self-Pay Life Only Rates
Effective April 1, 2024– March 31, 2025

Contract Type	Monthly Payment
Single (Retiree Only)	$10.11

UTILIZING THE RETIREE-ONLY HRA

- The Retiree-Only HRA benefit is an arrangement that reimburses you for eligible medical care expenses incurred by you and your eligible dependents.

- Your Retiree-Only HRA account's initial account balance will be equal to the balance of your Benefit Credit Account as of the day before your Retirement Date.

- When you receive a reimbursement from your Retiree-Only HRA account, your account balance will be reduced by the amount of the reimbursement.

- Under no circumstances will you be eligible for a Retiree-Only HRA if you are engaged in Covered Employment; you may not make contributions to your Retiree-Only HRA.

- Any unused amount in your Retiree-Only HRA as of December 31 of a coverage period will be rolled over for use in the following coverage period during your retirement.

- Eligible reimbursements/medical care expenses must not exceed the dollars available to you in your Retiree-Only HRA account. "Medical care expenses" are defined by Section 213(d) of the Internal Revenue Code. For more information, you can review IRS Publication 502.

Examples of common medical care expenses that you may be reimbursed for from your Retiree-Only HRA:

- Premiums for an individual health insurance policy covering you and your Covered Beneficiaries
- Premiums for COBRA continuation coverage from the Fund's group health plan benefit
- Out of pocket premiums paid by your Spouse for your coverage in your Spouse's employer's group health plan (but only if your Spouse pays those premiums after tax)
- Any co-pays, deductibles, or co-insurance payments you or your Covered Beneficiaries make out of pocket that are not reimbursed by another insurance policy
- Premiums you pay for Medicare coverage
- Certain dental or vision expenses as set forth in IRS Publication 502

FORFEIT and/or TERMINATION OF THE RETIREE-ONLY HRA

- Your Retiree-Only HRA account will be terminated when you reach the maximum reimbursement amount available to you in a coverage period (dollars available).

- If you return to Covered Employment after your Retirement Date, your Retiree-Only HRA account will be terminated and all amounts in your account will be forfeited.

- Your participation in the Retiree-Only HRA may prevent you from obtaining federal premium assistance to pay for individual health insurance coverage through the Health Insurance Marketplace. You may voluntarily terminate your Retiree-Only HRA at any time by contacting the Plan Administrator.

TERMINATION OF BENEFITS - RETIREES

- In any event, coverage in the Fund's Group Health Plan terminates as of the last day of the month before the Retired Participant attains the age of Medicare eligibility.

- Retired Participants will lose their death benefit coverage if they fail to Self-Pay in a timely and complete manner. Benefit coverage terminates as of the last day of the month that the Retired Participant paid for coverage.

- Any balance remaining in a Retired Participant's Dollar Bank will be forfeited as of the date they become eligible for or enroll in Medicare, whichever is earlier.

REINSTATEMENT OF COVERAGE - RETIREES

- Up to age 65, a Retired Participant returning to work must satisfy the Initial Eligibility requirements set forth above before eligibility for benefits can be reinstated. Please see above for initial eligibility rules.

- If you return to covered employment after your retirement date, your Retiree-Only HRA would be terminated and any remaining dollars would be forfeited.

COVERED BENEFICIARY ELIGIBILITY UPON A PARTICIPANT'S DEATH - RETIREES

- If a Participant was retired and was receiving benefits at the time of their death, their Covered Beneficiaries may continue to be covered until their Dollar Bank is exhausted. Once the Dollar Bank is exhausted, or if there are insufficient hours in the Dollar Bank, their Covered Beneficiaries may maintain eligibility by paying for COBRA.

- Coverage for Covered Beneficiaries will terminate upon the earliest of the following events:

    - The date on which the Covered Beneficiary no longer meets the Fund's definition of a Covered Beneficiary.

    - The date the spouse remarries

    - The date a Covered Beneficiary becomes covered by another group benefit plan or Medicare.

- Any extension of coverage to Covered Beneficiaries will be counted towards any additional coverage available under COBRA Continuation Coverage.

- If the participant is an eligible retiree and has obtained age 65 upon death, the Retiree Only HRA balance may only be transferred to the surviving spouse and may exhaust the HRA balance for qualified expenses.

- Surviving spouse must contact the Fund Office and shall provide proof of ACA compliant health coverage in order to receive reimbursement from the HRA.

TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **Life Insurance** (Active Employees only) – $10,000 through New York Life

Beneficiaries may contact I.E. Shaffer & Co. and ask to speak with a member of the Benefit Processing Department. Please be sure your beneficiary information is updated with the Fund Office and filed in writing.

- **Accidental Death and Dismemberment** (Active Employees only) – up to $10,000 through New York Life

- **Death Benefit (Retirees) -** $5,000 through the Welfare Fund (self-insured).
  - Self-pay retiree life insurance is due every January. Payments are made directly to I.E. Shaffer & Co. office.

Beneficiaries may contact I.E. Shaffer & Co. and ask to speak with a member of the Benefit Processing Department. Please be sure your beneficiary information is updated with the Fund Office and filed in writing.

- **Disability (**Active Employees only) – Maximum of $400 per week a maximum of 26 weeks
  - See following pages for plan information

- **Medical and Behavioral Health - Aetna**
  - Call Aetna at 833-732-1628 for more information or go to www.aetna.com
  - Visit www.aetna.com/docfind to find an in-network Aetna provider

- **Prescription –** See following pages for plan information
  - Call 888-792-3862 or go to www.aetna.com for more information
  - For Specialty Drugs and the Co-pay Assistance Program, call: PrudentRx at 1-800-578-4403 for more information

- **Dental – Delta Dental**
  - See following pages for plan information
  - Call Delta Dental at 1-800-932-0783 or go to www.deltadentalins.com for more information

- **Vision – VBA**
  - See following pages for plan information
  - Call VBA at 1-800-432-4966 or go to www.vbaplans.com for more information

DISABILITY BENEFIT

$400 weekly disability payable by the Welfare Fund for a maximum of 26 weeks or upon your return to work, whichever first. All disability payments are subject to federal income tax, FICA tax, and PA Unemployment Compensation Tax.

To be considered for disability benefits you must:

- be unable to perform any work as an Electrical Worker in the construction industry as a result of a disability resulting from non-occupational illness or injury

- be receiving medical treatment for your illness or injury by a State verified, licensed and credentialed physician who is able to provide:
    - written verification and description of the cause and first date of your disability
    - documentation of all received and anticipated future medical treatments and/or assessments for your disability
    - anticipated date of return to work

- file your disability claim within 6 months of your first day of illness or injury disability cause

- receive approval by the Plan Administrator

- The Fund reserves the right to have you examined by a health care professional designated and paid for by the Fund. Such examination may be repeated as often as may be reasonably required during continuance of the claim

If you meet the criteria for disability and have received approval, disability benefit payment shall commence:

- On the first date of your hospitalization due to illness

- On the first date you were deemed to be disabled due to injury caused by accident

- On the eighth day following your initial date of disability due to illness where you received medical care but were not hospitalized for the illness which caused your disability.

Your claim for Disability Benefits may be denied at any time if the Plan Administrator determines that you are not disabled from work due to a non-occupational illness or injury. You must return any Disability Benefits that you improperly received immediately upon demand by the Plan Administrator.

The Fund reserves the right to have you examined by a health care professional designated and paid for by the Fund. Such examination may be repeated as often as may be reasonably required during continuance of the claim.

Effective: 6/1/22 – 5/31/26
$0 Exam / $20 Materials Copay
Dependent Age: 26

Frequency Type: Last Date of Service	**Employee**	**Spouse**	**Children**
Vision Exam	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Frames	24 Months	24 Months	24 Months

Benefits: Employee Can Select Either	VBA Participating Provider Amount Covered/Benefit (After Applicable Copay)*	Out-of-Network Max Reimbursement (Zero Copay)
Vision Exam (Glasses or Contacts)	Covered in Full	$40
Retinal Screening with Exam (as of 10/13/22)	Copay not to exceed $39	N/A
Clear Standard Lenses (Pair):		
Single Vision	Covered in Full	$40
Bifocal	Covered in Full	$50
Blended Bifocal	Covered in Full	$50
Trifocal	Covered in Full	$75
Progressives	Partially-Covered	$75
Lenticular	Covered in Full	$100
Polycarbonate	Covered in Full for Persons Up to Age 19	N/A
Basic Scratch Coating	Covered in Full	N/A
Frame (Wholesale Allowance)	Up to $ 50	$50
-OR-		
Elective Contacts (in lieu of eyeglass benefits)		
Material Allowance	Up to $ 110[A]	$110
Elective Fitting Fee and Evaluation	15% off UCR	N/A
-OR-		
Medically Necessary Contacts	Covered in Full[B]	$320
Low Vision Aids (Per 24 Months. No Lifetime Max)	N/A	$650

Where an "allowance" is shown above, the Member is responsible for paying any charges in excess of the allowance less any applicable copay.

Benefits and participation may vary by location, including, but not limited to, Costco® Optical, Pearle Vision, LensCrafters®, Target Optical® and Boscov's™

A The allowance is applied to all services/materials associated with contact lenses, including, but not limited to, contact fitting, dispensing, cost of the lenses, etc. No guarantee the allowance will cover the entire cost of services and materials.

B Requires prior approval. May only be selected in lieu of all other material benefits listed herein.

* A $20 copayment is applied to the total cost of the lenses and/or frames ordered from a VBA Member Doctor only. Copayment does not apply to the routine vision examination or the contact materials.

IBEW LOCAL UNION 163 ANNUITY FUND

Effective January 1, 2023

The Fund has retained John Hancock Retirement Plan Services ("John Hancock") as a service provider for purposes of providing important self-directed investment features and services for Fund Participants. Through the services that John Hancock offers, you will be able to self-direct your investments in many different ways.

YOUR ACCOUNT BALANCE IS EQUAL TO:

- Employer Contributions, plus
- Investment Earnings, less
- Withdrawals, less
- Expenses

TYPES OF ANNUITY BENEFITS

- **Retirement**

  Unless you elect otherwise, benefits must begin on or before the sixtieth day after the close of the Plan Year in which the last of these occurs:

  1. you reach age 62, or
  2. you terminate work in Covered Employment with the intention of retiring.

  You may continue working after age 62, and you will not be required to have your benefits commence until you stop working in Covered Employment. If you stop working in Covered Employment with the intention of retiring, your benefits will begin on or before the sixtieth day after the close of the Plan Year in which you cease Covered Employment, unless you elect otherwise, but in no event later than April 1st of the calendar year following the later of the calendar year in which you attain age 70½, or April 1st of the calendar year in which you cease Covered Employment.

- **Disability**

  If you are not eligible for Early Retirement and become Disabled (*i.e.* you have been awarded Disability Benefits under the Social Security Act), you may request distribution of your account by making an application for distribution on a form approved by the Board of Trustees.

- **Withdrawal**
  If you are not eligible for Retirement and either: (a) you have not worked in Covered Employment or Industry Employment for a period of six (6) consecutive months; (b) you have demonstrated that you have exhausted your unemployment compensation benefits; (c) you have demonstrated that you are ineligible for unemployment compensation benefits; or (d) you are employed in non-Covered Employment by an Employer who is obligated to contribute to the Fund, you will be deemed to have terminated your employment.

- **Death**
  If you are married, your Eligible Spouse is entitled to a Qualified Pre-Retirement Survivor Annuity. Under the terms of this Fund, if you are married to an Eligible Spouse and you die prior to receiving any benefits, the value of your account will be used to purchase an annuity for your Eligible Spouse which will provide monthly payments for as long as your Eligible Spouse lives.

  If you are not married, or if you are married and your Eligible Spouse executes a valid waiver of a right to a Qualified Pre-Retirement Survivor Annuity, then your Eligible Spouse, beneficiaries or estate shall be entitled to apply for a lump-sum distribution of your account, or where permitted by law, may apply for any other distribution option available to you under the Fund's benefit provisions.

  A spouse's eligibility may be altered by a court order known as a Qualified Domestic Relations Order. The Qualified Domestic Relations Order may provide that a former spouse is entitled to a Qualified Pre-Retirement Survivor Annuity. The Qualified Pre-Retirement Survivor Annuity will be paid according to the terms of the Qualified Domestic Relations Order.

- **Hardship Withdrawals**

  Your Plan Account is intended to provide benefits when you retire. In limited circumstances where you can demonstrate a financial hardship, a pre-retirement distribution from your Profit-Sharing Account — a hardship withdrawal — may be permitted. The Plan Administrator has full authority and discretion to determine eligibility for a hardship withdrawal.

  Hardship withdrawals are permitted by the Plan only for the following reasons:

  - to alleviate an extraordinary financial hardship due to illness or disability of you, your Spouse, or your children or other dependents.

  - to purchase or preserve real property that is (or will serve as) your principal residence;

- to finance the cost of postsecondary education for your children or dependents; or

- to alleviate any extraordinary financial hardship outside of your business affairs (other than those set forth above).

The following rules apply to hardship withdrawals:

- Spousal consent is required with your hardship withdrawal application.

- You must certify the existence of a financial hardship and present supporting documentation of the need for a hardship withdrawal.

- The hardship withdrawal amount is limited to the cash amount needed to alleviate the hardship.

- The hardship withdrawal amount cannot exceed the value of your Profit-Sharing Account.

Amount and Form of Distribution

The amount withdrawn cannot be more than the amount necessary to satisfy the financial hardship plus the amount necessary to pay federal, state, and local income taxes and penalties reasonably expected to result from the withdrawal. Hardship withdrawals are only paid in a lump sum payment. For more information or to request a hardship withdrawal application, contact the TPA.

Limitations

A hardship withdrawal is not eligible for rollover to an individual retirement account or an eligible employer plan, and mandatory 20% federal income tax withholding does apply to the withdrawal.

FORMS OF PAYMENT

- Lump Sum
- Monthly installments over a period not to exceed your life expectancy
- Combination lump sum and monthly installments
- Joint and survivor annuity

FEDERAL AND STATE INCOME TAXES

- Annuity benefits are subject to federal and state income taxes.
- Mandatory 20% withholding applies to all payments made over less than 10 years.
- 10% IRS penalty applies if you are not 59½ or 55 and retired.
- May qualify for rollover treatment.

John Hancock has an easy-to-use, toll-free "800" telephone number that gives you immediate access to information about your Account 24 hours a day, seven days a week. By calling 1-800-294-3575 from a touch-tone phone, you can:

- make your initial investment selections
- check your Account balances
- get a daily valuation of your Account
- make changes and transactions on a daily basis
- change your PIN
- change your user identification

When you call the toll-free number from a touch-tone telephone, a recorded voice guides you through the transaction. When you call the John Hancock 800 number for the first time you will need to verify your Social Security Number (Account Number) and date of birth. You will then be prompted to create your Personal Identification Number (PIN).

You can access the John Hancock website at https://myplan.johnhancock.com/login . When you first use the website, you will be prompted to enter your Social Security Number and verify your date of birth. After entering this information, you will be asked to create a PIN that you will use in the future when you self-direct your investments, either by the John Hancock 800 number or on the John Hancock website. If you do not wish to use your Social Security Number as your user identification, you can also create a new user identification that you will utilize in the future when you self-direct your investments on the John Hancock website. You will also be asked to create a security question and answer that will be used in the future when you access the John Hancock website.

If you have any questions or problems with the John Hancock website, you can contact a John Hancock Participant Service Representative at 1-800-294-3575.