IBEW LOCAL UNION 269
WELFARE, PENSION, ANNUITY & SUPPLEMENTAL 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 269 Welfare, Pension, Annuity and Supplemental 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 269 WELFARE FUND

Effective January 1, 2025

ELIGIBILITY RULES – ACTIVE EMPLOYEES

INITIAL ELIGIBILITY

You will become initially eligible on the first day of the second month following a calendar quarter during which you complete 1,200 hours of service in the prior 12-month period.

Upon satisfying the initial eligibility requirements, you will remain eligible for at least 6 months.

If You Work 1200 Hours Between:	You Will Become Eligible On:	And Remain Eligible Until:
January 1 – December 31	February 1	August 31
April 1 – March 31	May 1	November 30
July 1 – June 30	August 1	February 28/29
October 1- September 30	November 1	May 31

Note: During your first year of eligibility, you will not be eligible for life insurance, accidental death and dismemberment, dental or vision benefits.

CONTINUED ELIGIBILITY AND TERMINATION

To maintain your eligibility after satisfying the initial requirement, you must have at least 300 hours of service each calendar quarter. Your eligibility will terminate on the last day of the second month following the calendar quarter during which you fail to receive credit for at least 300 hours.

If You Have Less Than 300 Hours of Credit Between:	Your Eligibility Will Terminate On:
January 1 – March 31	May 31
April 1 – June 30	August 31
July 1 – September 30	November 30
October 1 – December 31	February 28 (29)

Hours of service in excess of the hours required to establish and maintain eligibility will be placed in a reserve and will accumulate up to a maximum of 600 hours. These reserves will be drawn upon to maintain your eligibility if you should fail to receive credit for at least 300 hours

of service during a subsequent calendar quarter. If you are eligible for benefits as a retired employee, your accumulated reserve hours will be eliminated upon your retirement.

If you become disabled while eligible, you will be credited with 25 disability hours for each week that you are disabled up to a maximum of 600 hours for any one continuous period of disability. If you serve on active duty of the United States military while eligible, you will be credited with 25 hours for each week of active duty service.

REINSTATEMENT

Should your eligibility terminate, it will be reinstated provided you are credited with at least 300 hours of service during a calendar quarter and you are not out of employment with a contributing employer for more than 12 months. For purposes of this provision, your termination date will be either the date you terminated as an active employee or the date you terminated from self-pay continuation of coverage under COBRA. Your eligibility will reinstate on the first day of the second month following that calendar quarter during which you meet this 300 hour requirement. If you do not satisfy this reinstatement provision, you will be treated as a new employee and will be subject to the 1200 hour requirement for initial eligibility outlined above.

Termination Date:	**Period of Time to Work a Total of 300 Hours (Plus, any Remaining Reserve Hours) To Reinstate:**
February 28 (29)	October 1 of the prior year – December 31
May 31	January 1 – March 31 of the next year
August 31	April 1 – June 30 of the next year
November 30	July 1 – September 30 of the next year

Your eligibility will reinstate on the first day of the second month following that calendar quarter during which you meet this 300-hour requirement.

If You Are Credited with Your Required 300th Hour to Reinstate Between:	**Your Eligibility Will Reinstate On:**
January 1 – March 31	May 1
April 1 – June 30	August 1
July 1 – September 30	November 1
October 1 – December 31	February 1

NON-BARGAINING EMPLOYEES

If you are a non-bargaining employee of an eligible participating employer, you will become eligible on the first day of the month following your employment. Your eligibility will terminate on the last day of the month that follows the month for which your employer last makes required contributions.

COBRA

If you or your dependent loses eligibility, self-pay continuation of coverage is available under COBRA for a limited period of time. Your accumulated reserve hours will be applied before self-pay is required. The current monthly self-pay rates under COBRA are:

	Full Plan
Single	$ 590.00
H/W or Parent/1 Child	$ 1,020.00
Family	$ 1,540.00

ELIGIBILITY RULES – RETIRED EMPLOYEES

Following your retirement, you will be eligible for retiree benefits provided all the following requirements are satisfied:

- You have been eligible for benefits under the Welfare Fund as an active employee for at least 16 of the 20 years prior to your retirement.
- You have attained age 55 or are totally disabled.
- You are entitled to receive a retirement benefit from the IBEW Local 269 Pension Fund or you have been eligible as a non-bargaining employee.
- You make the required contributions in the amount established by the Trustees. If you have attained age 65 or are totally disabled, no contribution is required. The required monthly contribution for early retirees under age 65 is as follows:

Single: $708
Parent and 1 Child: $1,224
Husband & Wife: $1,224
Family: $1,848

If you fail to make the required contributions prior to age 65, you will not be eligible as a retired employee after age 65.

The health insurance provided by the Welfare Fund to Medicare eligible individuals is secondary to Medicare (Part A and Part B). This coverage provided by the Welfare Fund requires Medicare eligible individuals to be enrolled in Medicare Part A and B. It's important you or your dependent spouse sign up promptly for Part A and B to avoid gaps in coverage or late enrollment penalties. In general, individuals become eligible for Medicare on the first day of the month upon attainment of age 65, or 24 months after becoming eligible for Social Security Disability benefits, if earlier.

ELIGIBILITY RULES – DEPENDENTS

1. The spouse of the employee under a legally valid existing marriage under the laws of the state where the covered employee lives.

2. The employee's natural child, stepchild, legally adopted child, foster child or legal ward **provided the child has not reached the end of the month in which he or she turns 26 years of age**.

3. Any other child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgement, decree, or order as being entitled to enrollment for coverage under the Plan, even if the child is not residing in the employee's household.

4. Adopted children, who are less than 18 years of age at the time of adoption, shall be considered eligible from the date the child is placed for adoption.

5. A child who is unmarried, incapable of self-sustaining employment and dependent upon the employee for support due to intellectual disability and/or physical disability, and who was covered under the Plan prior to reaching the maximum age limit or other loss of dependent's eligibility, will remain eligible for coverage under this Plan beyond the date coverage would otherwise be lost.

The Fund will require proof of dependent status.

DEPENDENT COVERAGE IN THE EVENT OF YOUR DEATH

Spouse and dependent children of a participant who was eligible for ACTIVE coverage (not on COBRA) at the time of death:

Following your death, your surviving spouse and dependent children will remain eligible for health benefits until the earliest of the following dates:

1. The last day of a period of 12 months following your death or to the extent that your reserve hours are sufficient to maintain your eligibility, whichever is longer. Your surviving spouse and dependent children are covered at no cost for this 12-month period.
2. The date your surviving spouse remarries.
3. The date surviving spouse becomes eligible for health benefits under another group plan.
4. The date the dependent children cease to meet the definition of eligible dependent under the Plan (i.e. attaining the maximum eligible age).

Surviving spouses and dependent children of active participants may continue coverage for an indefinite period of time at the current COBRA rates. If your spouse remarries, the self-pay privilege ends at the end of a maximum 36-month period or date of marriage, if later.

Should there only be children surviving (no spouse) after the 12 months of guaranteed coverage, the dependent children would be able to continue the coverage for up to 36 months under COBRA.

Spouse and dependent children of a participant who was RETIRED (not on COBRA) at the time of death:

Following your death, your surviving spouse and dependent children will remain eligible for health benefits until the earliest of the following dates:

1. The last day of a period of 12 months following your death or to the extent that your reserve hours are sufficient to maintain your eligibility, whichever is longer. Surviving spouses and dependent children are covered at no cost for this 12-month period.
2. The date your surviving spouse remarries.
3. The date surviving spouse becomes eligible for health benefits under another group plan.
4. The date the dependent children cease to meet the definition of eligible dependent under the Plan (i.e. attaining the maximum eligible age).

Surviving spouses of retired participants may continue Single or Parent/Child coverage for an indefinite period of time at the current COBRA rates. In the case of a surviving spouse who is Medicare Primary, the monthly premium is $200 or the current Parent/Child COBRA rate if your dependent children are to be covered. If your spouse remarries, the self-pay privilege ends at the end of a maximum 36-month period or date of marriage, if later.

Should there only be children surviving (no spouse) after the 12 months of guaranteed coverage, the dependent children would be able to continue the coverage for up to 36 months under COBRA.

IBEW LOCAL 269 WELFARE FUND

TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **LIFE INSURANCE - Active employees only** – $20,000

- **ACCIDENTAL DEATH & DISMEMBERMENT - Active employees only** – $20,000

- **MEDICAL – AETNA**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for more information

- **PRESCRIPTION – CAPITAL RX (Actives and Non-Medicare Retirees)**
  RETIREEFIRST (Medicare Eligible Retirees)
  - See following pages for plan information
  - Call Capital Rx at 1-855-922-7795 (Actives and Non-Medicare Eligible Retirees) for more information
  - Call RetireeFirst at 1-866-302-7770 (Medicare Eligible Retirees) for more information

- **DENTAL – DELTA DENTAL OR DENTAL SERVICES ORGANIZATION (DSO)**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for more information

- **VISION – AETNA**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for more information

- **HEARING – AETNA**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for more information

- **BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS**
  Actives and Non-Medicare Eligible Retirees
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for claim & service inquiries.

AETNA RESOURCES FOR LIVING EMPLOYEE ASSISTANCE PROGRAM (EAP)

You can call Resources for Living anytime — 24/7/365 — for confidential support with:

- Stress
- Depression and anxiety
- Drug and alcohol problems

- Relationship issues
- Anger and conflict
- Parenting challenges
- Work issues and more

If you'd like to talk with a counselor, Resources for Living will help you find a network provider in your area. Each covered individual is eligible for up to 3 free counseling sessions per issue each year. You will need to contact Resources for Living to authorize your free sessions. You can choose to work with a counselor face to face, by phone or by video conference ("televideo").

Call 1-888-238-6232

or

go to www.resourcesforliving.com

- Select "Company login/Register"
- Enter **Local 269** as Employer/Organization Username
- Enter **EAP** as access code
- Click "Log in to site" button

Aetna Resources for Living will help coordinate care with Aetna Behavioral Health for any treatment requiring inpatient services. See below.

AETNA BEHAVIORAL HEALTH

All in-patient treatment relative to behavioral health and substance use disorder conditions must receive prior authorization from Aetna Behavioral Health

Call Aetna Behavioral Health at 1-800-424-4047, option 4 - 24/7/365 for urgent clinical matters

- **MEDICARE SUPPLEMENT** - Fund pays as a supplement to Medicare. Subject to a calendar year deductible of $200 per person or $500 per family. Payable at 80% up to out-of-pocket maximum of $1,000 per person/$2,500 per family

NOTE: DURING YOUR FIRST YEAR OF ELIGIBILITY, YOU WILL *NOT* BE ELIGIBLE FOR LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, DENTAL, VISION OR HEARING BENEFITS.

IBEW LOCAL UNION 269 WELFARE FUND

SCHEDULE OF BENEFITS

AETNA PPO NETWORK
EFFECTIVE DATE: January 1, 2025

MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE		
(Calendar Year)		
Individual	$0	not covered
Family	$0	not covered
ANNUAL OUT-OF-POCKET MAXIMUM – In Network Only		
(Copays, deductibles, and coinsurance count towards this out-of-pocket limit).		
The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage. An individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum.		
Individual	$4,600	not applicable
Family	$9,200	not applicable

***Medicare Eligible Plan Participants** – Fund pays as a supplement to Medicare subject to a calendar year deductible of $200 per person or $500 per family. Payable at 80% to out-of-pocket maximum of $1,000 per person/$2,500 per family. Please note that Medicare eligible participants (with the exception of those that are still either actively employed or the dependents of active employees) must enroll in Medicare Parts A & B. The Welfare Fund will enroll these individuals in its own Medicare Part D plan

CO-INSURANCE	100%	not covered
LIFETIME MAXIMUM	unlimited	not applicable
DOCTOR'S OFFICE VISITS		
Primary Care Office Visit	100% after $20 co-pay	not covered
Specialist Office Visit	100% after $20 co-pay	not covered
Maternity Visits	100% after $20 co-pay (applies to 1st visit only)	not covered
Urgent Care	100% after $20 co-pay	not covered

	IN-NETWORK	OUT-OF-NETWORK
PREVENTATIVE CARE (as defined by the Patient Protection and Affordable Care Act)		
	100% coverage	not covered
DIAGNOSTIC PROCEDURES		
Laboratory	100% coverage	not covered
Radiology	100% coverage	not covered

*Out-of-network tests are not covered except for services rendered by hospital-based pathologists and radiologists at in-network hospitals. Participants must use Quest Diagnostics. $20 co-pay if performed in doctor's office.

HOSPITAL CARE		
Inpatient Admission	100% coverage	not covered
Inpatient Physician Services	100% coverage	not covered
Surgery in Hospital	100% coverage	not covered
Outpatient Hospital Services	100% coverage	not covered

*Inpatient hospital care requires prior authorization

EMERGENCY CARE		
Emergency Room	100% after $50 copay	100% after $50 copay

*This copay is waived if admitted

Ambulance	100% coverage	100% coverage

*Covers transport if emergent and medically necessary

OUTPATIENT SURGERY		
Hospital Outpatient Surgery	100% coverage	not covered
Surgery in Ambulatory SurgiCenter	100% coverage	not covered
BEHAVIORAL HEALTH		
Office Visit	100% after $20 co-pay	not covered
Inpatient	100% coverage	not covered

*Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization

SUBSTANCE USE DISORDER		
Office Visit	100% after $20 co-pay	not covered
Inpatient	100% coverage	not covered

*Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization

OTHER SERVICES		
Chiropractic Care Visit	100% after $20 co-pay	not covered

*Up to 30 visits per person per calendar yea

	IN-NETWORK	OUT-OF-NETWORK
Home Health Care Services	100% coverage	not covered
*Maximum 120 visits per calendar year, 4 hours=1 visit, no custodial care. Prior authorization required.		
Hospice Services	100% coverage	not covered
*For outpatient –maximum 120 visits per calendar year. Excludes respite care, pastoral care and counseling.		
Skilled Nursing Care		
Inpatient	100% coverage	not covered
Outpatient (at home)	100% coverage	not covered
Outpatient (at facility)	100% coverage	not covered
*Maximum 120 days per calendar year. Medical treatment only.		

THERAPY SERVICES

Occupational Therapy	100% after $20 co-pay	not covered
Physical Therapy	100% after $20 co-pay	not covered
Respiratory Therapy	100% after $20 co-pay	not covered
Speech Therapy	100% after $20 co-pay	not covered
*unlimited visits per person per calendar year		
All Other Covered Medical Services	100% coverage	not covered

Prior Authorization Requirements

All in-patient hospital stays must receive prior authorization from **Aetna at 1-888-632-3862**. Emergency admissions must be authorized within 72 hours after hospital admission. No benefits will be paid for treatment that does not receive prior authorization.

All in-patient treatment relative to behavioral health and substance use disorder conditions must receive prior authorization from **Aetna Behavioral Health at 1-800-424-4047, option 4**. No benefits will be paid for treatment that does not receive prior authorization.

In-Network Only

The medical coverage provided under the Plan is **in-network only**.

How to Find an AETNA Healthcare Provider

- Ask your physician, hospital, lab or other provider
- Go to Aetna's website at **www.aetna.com/docfind**. Go to "Continue as a guest" and enter your zip code and hit the search button. Then select a plan – your plan is Aetna Choice POS II (Open Access) – and then hit continue button. On next page, type in provider's name or a specialty you are looking for or find what you need by category.
- Call I.E. Shaffer & Co. at 1-800-792-3666

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider you did not elect at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. This Plan does NOT provide elective out-of-network benefits, meaning if you elect to have care with an out-of-network provider, the Plan may not pay for such services.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition **unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.**

Federal Law

The Consolidated Appropriations Act, 2021 (CAA) was signed into law on December 27, 2020. The CAA includes a provision known as the No Surprises Act. No Surprises Act opens a dialog window, which establishes protections from surprise billing, effective January 1, 2022. The No Surprises Act offers protections that are similar to the New Jersey OON Mandate and applies to those surprise bills not subject to the New Jersey OON Mandate, including bills for care provided outside of New Jersey and air ambulance services, if air ambulance is a covered benefit under a health plan's contract.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network to avoid balance billing.

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed or have questions, please contact I.E. Shaffer & Co. and ask to speak with the Manager of the Claims Department at (609)-718-6147.

You may visit *<u>www.cms.gov/nosurprises/consumers</u>* for more information about your rights under federal law.

IBEW LOCAL UNION 269 WELFARE FUND

PRESCRIPTION DRUG BENEFIT

Active Employees and Non-Medicare Eligible Retirees

Please call CAPITAL RX at 1-855-922-7795 for more information

Participating Retail Pharmacy

Mandatory generic substitution (no dispense as written) * - see note below
Maximum **30-day** supply:

- Generic Drugs – $5 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $100 maximum
- Non-Preferred Brand Name Drugs – 40% co-payment

Maximum **90-day** supply:

- Generic Drugs - $10 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $200 maximum
- Non-Preferred Brand Name Drugs – 40% co-payment

Mail Order Prescriptions

Mandatory generic substitution (no dispense as written) * - see note below
Maximum **90-day** supply:

- Generic Drugs – $10 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $300 maximum
- Non-Preferred Brand Name Drugs – 40% co-payment

Specialty Medication

- Preferred Brand Name Drugs – 20% co-payment, $200 maximum
- Non-Preferred Brand Name Drugs– 20% co-payment, $250 maximum

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After $2,000 per person or $4,000 per family of out-of-pocket prescription expenses during a calendar year, there will be no co-payments required for the remainder of the year.

*If a name brand drug with a FDA approved generic is requested, the total co-payment will be the generic co-payment plus the difference in cost between the brand and generic medications. This penalty is not subject to the maximum co-payment limitations.

The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage (an individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum).

IBEW LOCAL UNION 269 WELFARE FUND

PRESCRIPTION DRUG BENEFIT

Medicare Eligible Retirees & Medicare Eligible Spouses

Please call RETIREEFIRST at 1-866-302-7770 with any questions about your Medicare Part D Prescription Benefits

Participating Retail Pharmacy

Group Medicare Part D Plan from RetireeFirst

Maximum **30-day** supply

- Generic Drugs - $5 co-payment
- Preferred Brand Name Drugs – $20 co-payment
- Non-Preferred Brand Name Drugs – $40 co-payment

Maximum **90-day** supply

- Generic Drugs - $10 co-payment
- Preferred Brand Name Drugs - $40 co-payment
- Non-Preferred Brand Name Drugs - $80 co-payment

Mail Order Prescriptions

Group Medicare Part D Plan from RetireeFirst

Maximum **90-day** supply

- Generic Drugs – $10 co-payment
- Preferred Brand Name Drugs – $40 co-payment
- Non-Preferred Brand Name Drugs –$80 co-payment

Specialty Medication

Group Medicare Part D Plan from RetireeFirst

- 25% co-payment, $250 maximum

Understanding the Prescription Drug Formulary

The drug formulary utilized by the Welfare Fund is a list of medications published by the Welfare Fund's Pharmacy Benefit Managers. Medications on the list fall into one of the four categories:

Generic Drugs – Generic drugs are the un-branded form of a prescription medication. They use the same active ingredients as brand name drugs and work the same way. The FDA puts all generic drugs through a rigorous, multi-step process to ensure that they are the therapeutic equivalent of their brand name counterparts. That means that a generic drug can be substituted for a brand name drug, and it will produce the same clinical effect while meeting the same safety profile as the brand name drug.

Preferred Brand Name - These brand-name drugs have been identified as the most therapeutically safe and effective options for treatment of most medical conditions. These drugs do not have less-costly generic equivalents because they are sold under a trademarked name.

Non-Preferred Brand Drugs - These products often have either a generic equivalent or a preferred-brand drug alternative.

Specialty Drugs – Specialty pharmaceuticals is a class of prescription drugs that are typically produced through biotechnology (sometimes known as biologicals) and require special patient monitoring and handling, in addition also require unique education prior to use.

DENTAL BENEFIT

Two options, annual election effective January 1st of each year:

DELTA DENTAL:

- Annual Deductible:
  - In-Network (Delta Dental) – None
  - Out-of-Network - $50/person or $150/family
- Benefit Payable:
  - In-Network (Delta Dental) – 85% of reasonable and customary charges
  - Out-of-Network – 80% of reasonable and customary charges
- Annual Maximum Benefit - $2,000/person
- Orthodontia Benefit – 80% reimbursement up to a lifetime maximum of $2,000/person

OR

DENTAL SERVICES ORGANIZATION (DSO) dental plan under which all treatment is provided at Eastern Dental offices located in New Jersey. Features of the DSO dental plan include:

- No deductible
- No annual benefit maximum
- Covers preventative, restorative, orthodontic and periodontic care
- No patient paid expenses with the exception of a 24 month maximum for orthodontics of: $500 for children/$1,250 for adults
- No need to submit claim forms

HEARING BENEFIT

Hearing Aid and Exam 100% coverage

- Unlimited benefit up to age 15.
- Up to $500 maximum for age 15 and over
- Maximum benefit payable once every 36 months

NOTE: DURING YOUR FIRST YEAR OF ELIGIBILITY, YOU WILL *NOT* BE ELIGIBLE FOR LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, DENTAL, VISION OR HEARING BENEFITS.

VISION BENEFIT

Adults (over 19 years old):

Routine vision screening per person per calendar year	100% after $20 co-pay
Frames/lenses or contact lenses per person per calendar year	Up to $500
Lifetime LASIK (vision correction *surgery*) benefit per person	$2,500

Dependent Children (up to age 19):

Routine vision screening per person per calendar year	100%
Standard frames*/lenses or contacts per person per calendar year	100%

*Standard frame refers to frames that are not designer frames such as Coach, Burberry, Prada and other name brand designers

IBEW LOCAL UNION 269 WELFARE FUND
BENEFIT PLAN MAXIMUMS

Annual Delta Dental Maximum - $2,000/person

Annual In-Network Medical Maximum Out-of-Pocket Limit-$4,600 person/$9,200 family
(Co-pays, deductibles and co-insurance count towards this out-of-pocket limit)

Annual Prescription Maximum Out-of-Pocket Limit - $2,000 person/$4,000 family
(Prescription co-pays count towards this limit)
For active employees and non-Medicare eligible retired employees only

Chiropractic Care Maximum – 30 visits per person per calendar year

Hearing Aids – Up to age 15 – unlimited benefit. Age 15 and older - $500 every 36 months

Home Health Care Maximum - 120 visits per calendar year, 4 hours = 1 visit, no custodial care covered

Hospice Care Maximum – 120 visits per calendar year. Excludes respite care, pastoral care and counseling

Lifetime Dental Orthodontia Maximum (Delta Dental) - $2,000/person

Lifetime maximum for surgical procedures performed to correct myopia (near sightedness) or hyperopia (far sightedness) - $2,500 per person

Skilled Nursing Care Maximum – 120 days per calendar year. Medical treatment only

Speech Therapy Maximum – no visitation limit

****BARIATRIC SURGERY IS NOT COVERED BY THIS PLAN****

IBEW LOCAL UNION 269 PENSION FUND

Effective January 1, 2022

IMPORTANT TERMS

- Plan Year - January 1st to December 31st
- Credited Service
    - For service after 12/31/2010, .1 year of credit for each 100 hours of service up to a maximum of 1 year of credit for 1,000 hours.
    - For service after 1/1/79, 1/4th year of credit for each 250 hours of service up to a maximum of 1 year of credit for 1,000 hours.
    - For service from 1/1/76 to 12/31/78, ½ year of credit for each 375 hours of service up to a maximum of 1 year of credit for 750 hours.
    - For service from 1/1/57 to 12/31/75, 1 year of credit for 500 hours of work.
    - For service prior to 1/1/57, credit is based upon either membership in the union or at least 500 hours of covered employment during a year.
- Vested Service - same as credited service.
- Vesting - 100% after 5 years vested service.
- Forfeiture - occurs if prior to becoming vested you incur a period of 5 consecutive 1-year breaks in service.
- Break in Service - any plan year during which you do not earn any credited service.
- Reserve Hours - ¼ year of additional credit for each 250 hours of service over 1,000 during a plan year after 1/1/82 up to a maximum of ½ year of credit. Additional credit is applied first to years prior to 1/1/76 in which less than 1 year of credited service was earned in descending order and then to years from 1/1/76 to 12/31/85 in ascending order.

TYPES OF PENSION BENEFITS

- Normal Retirement – payable at age 62 with 5 years of participation.
- Early Retirement – payable at age 55 with 5 years of credited service.
- Disability Retirement – payable at any age, with Social Security Disability, and 10 years of credited service including 5 years in the last 10 years.

NORMAL RETIREMENT BENEFITS

A lifetime monthly benefit payable for life starting at normal retirement age equal to:

- $1.00 per month for each full $110.00 of contributions during a plan year after 1/1/2022, plus
- $1.00 per month for each full $125.00 of contributions during a plan year after 1/1/2019, plus
- $1.00 per month for each full $137.00 of contributions during a plan year from 1/1/2010 to 12/31/18, plus
- $1.00 per month for each full $100.00 of contributions during a plan year from 1/1/2003 to 12/31/2009, plus
- $1.00 per month for each full $58.00 of contributions during a plan year from 1/1/1986 to 12/31/2002, plus
- $50.00 per month for each year of credited service prior to 1/1/86.

EARLY RETIREMENT BENEFITS FOR ACTIVE (NON-TERMINATED VESTED) EMPLOYEES

Same as Normal Retirement amount reduced by 1/6% for each month that you retire prior to age 62. For example, at age 60 your benefit would be reduced by 4%. At age 58 your benefit would be reduced by 8%. At age 55 your benefit would be reduced by 14%. There is no reduction in your benefit if the total of your age and years of credited service is at least 85 ("Rule of 85").

Plus, a supplement payable until age 62 equal to your early retirement benefit determined above, provided you have been credited with at least 16 years of credited service during the 20 plan years immediately preceding your retirement, including 3 years of credit during the last 5 years.

DISABILITY RETIREMENT BENEFITS

Same as Normal Retirement amount with no reduction for early retirement and no supplemental benefit.

FORMS OF PAYMENT

- Life Annuity with 60 payments guaranteed
- Spouse's Joint and 50%, 75% or 100% to Survivor (with pop-up)

PRE-RETIREMENT DEATH BENEFITS

Vested Employee Under Age 55

- Lifetime benefit payable to your spouse, beginning when you would have reached age 55, equal to ½ the amount you would have received at age 55 under the spouse's joint and 50% survivor form, or if the commencement date of this benefit would be more than 12 months after your death,
- $5,000 times your years of credited service payable in a lump sum.

Vested Employee Over Age 55

- Lifetime benefit payable to your spouse equal to ½ the amount you would have received had you retired under the spouse's joint and 50% to survivor form, or
- If you are unmarried, a monthly benefit equal to the benefit you would have received had you retired, payable for 60 months.

POST RETIREMENT DEATH BENEFITS

- Continuation of monthly benefit based upon form of payment elected at retirement, plus
- $2,000

IBEW LOCAL UNION 269 ANNUITY FUND

Effective November 1, 2019

YOUR ACCOUNT BALANCE IS EQUAL TO:

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

TYPES OF ANNUITY BENEFITS

- Retirement – payable if age 55 and retired from the Industry.

- Disability – payable if totally and permanently disabled.

- Termination – payable if no covered employment over 3 consecutive months (90 days).

- Death - payable upon death.

- Financial Hardship - If you have been a participant under the Plan for at least 3 years, you may apply for a withdrawal of up to $10,000.00. Contributions and earnings credited to your account during the last three plan years are not available for withdrawal. Hardship distributions are limited to once every two years (24 months) and are available for the following purposes:

    - Unemployment – upon the exhaustion of state unemployment benefits.

    - Death of a dependent.

    - To cover repairs for uninsured or under insured damage to your principal residence as a result of a natural disaster.

FORMS OF PAYMENT

After retirement, participants may elect to receive their benefits from one of the following forms of payment:

- Spouse Joint and 50% to Survivor Life Annuity – If you are married, your annuity benefits can be paid to you in the form of a monthly annuity benefit for your lifetime, with the provision that if you are survived by your spouse, they will receive 50% of such monthly annuity benefits for the remainder of his or her lifetime.

- Lump Sum payment.

- Monthly installments.

- By combination of lump sum and monthly installments.

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.

IBEW LOCAL 269 ANNUITY FUND INVESTMENT OPTIONS

Stable Value Fund

- IBEW 269 Annuity Stable Value

Specialty

- Vanguard Real Estate Index

Small Cap Funds

- Principal SmallCap S&P 600 Index
- Vanguard Explorer
- Vanguard Small Cap Value Index

Large Cap Funds

- Allspring Growth
- American Beacon The London Company Income Equity
- Fidelity Contrafund
- NYLI S&P 500 Index

International Fund

- iShares MSCI Total International Index

Bond Funds

- PGIM High Yield
- Vanguard Total Bond Market Index

Balanced Fund

- Dodge & Cox Balanced

Asset Allocation

- Fidelity Advisor Freedom – Income, 2010, 2015, 2020, 2025, 2030, 2035, 2040, 2045 and 2050

Access your account with your PIN 24 hours a day, 7 days a week – www.empowermyretirement.com or (844) 465-4455 (toll-free).

IBEW LOCAL 269 SUPPLEMENTAL FUND

Effective July 1, 2020

INITIAL ELIGIBILITY RULES

You will become an eligible participant in the IBEW Local 269 Supplemental Fund on January 1st, following attainment of 3,000 benefit credits. When your employer contributes to the Plan on your behalf, you receive benefit credits. You will receive 1 benefit credit for each hour for which you are paid as a result of covered employment. You have 5 calendar years to earn these 3,000 benefit credits and the credits are forfeited after 5 years if you do not become eligible.

DOLLAR BANK

Your Dollar Bank will be based upon the number of hours for which you are paid multiplied by the IBEW Local 269 Supplemental Fund's hourly contribution rate at the time the hours are worked.

CONTINUED ELIGIBILITY

In order to maintain your eligible status in any year after you meet the initial eligibility requirements, you must have a balance in your Dollar Bank account and you must not incur 5 consecutive full calendar years with no covered employment and contributions into your Dollar Bank.

TERMINATION

Your last day of participation will be the date that your Dollar Bank balance becomes zero or January 1st of the year following 5 full calendar years with no covered employment and contributions into your Dollar Bank. If you retire and begin to receive a Pension benefit from the IBEW Local 269 Pension Plan, you will no longer be considered an IBEW Local 269 Supplemental Fund participant.

REINSTATEMENT

If your Dollar Bank balance goes down to zero, you must earn 1,500 benefit credits in a calendar year in order to be reinstated the following January 1st. If you do not earn 1,500 benefit credits in the 3 years following termination, you are subject to the initial eligibility rules above.

BENEFITS

1. **Weekly Supplemental Unemployment Benefit (SUB) - DEDUCTED FROM DOLLAR BANK**
   - To be eligible for this benefit you must:
     - Have filed for and are entitled to state unemployment benefits for the week
     - Are available for work, have signed the IBEW Local 269 out of work list and have not failed to report to work or refused to accept employment
     - The benefit is $150 per week if you are receiving state unemployment or if you have exhausted state unemployment benefits, up to $450 per week in $150 increments if you have a sufficient Dollar Bank balance

     You are not eligible for SUB if you are:

     - Collecting retirement benefits from an IBEW Pension Fund
     - Collecting short term disability benefits
     - Collecting workers compensation
     - Collecting weekly Supplemental Sick Benefits (SSB) from the Supplemental Fund

2. **Monthly Supplemental Health and Welfare Benefit (SHWB) - NOT DEDUCTED FROM DOLLAR BANK**

   The SHWB makes the required contributions for retiree coverage to the IBEW Local 269 Welfare Fund for a retired single participant or a retired married participant and spouse.

   - **To be eligible for this benefit you must:**
     - Qualify for retiree coverage from the IBEW Local 269 Welfare Fund

     SHWB payments on eligible retirees are automatically transferred from the IBEW Local 269 Fund Supplemental to the IBEW Local 269 Welfare Fund on a monthly basis. Participants receiving SHWB monthly benefits can self-pay to continue to provide Welfare Fund coverage for their dependents as follows:

Single retiree and 1 child	$516 per month
Single retiree and 2 or more children	$1,140 per month
Retiree and spouse with 1 or more children	$624 per month

3. **Supplemental Health Benefits Extend Coverage Subsidy (ECS) - NOT DEDUCTED FROM DOLLAR BANK**
   - **To be eligible for this benefit you must:**
     - Have terminated from coverage from the IBEW Local 269 Welfare Fund and eligible for COBRA

- Have filed for state unemployment
- Registered on the IBEW Local 269 out of work list and maintain the registration
- Have been involuntarily laid off and not discharged for cause or quit covered employment in the last 12 months
- Not refuse any referrals after three attempts of employment from the Local 269 hiring hall

ECS payments on eligible participants are automatically transferred from the IBEW Local 269 Fund Supplemental to the IBEW Local 269 Welfare Fund on a monthly basis

4. Individual Supplemental Fund- DEDUCTED FROM DOLLAR BANK

- If the total audited value of the IBEW Local 269 Supplemental Fund is the greater of two years of reserve or $10M at the end of a Plan Year, the following year will be an individual account year
- In March of the next year, the total dollars contributed to your dollar bank in the preceding calendar year will be paid to you
- Participants with a Dollar Bank of less than $10,000 can elect to either receive the disbursement or have their earned credits remain in their individual accounts
- The Individual Supplemental Fund payment will be limited to the lessor of the dollars contributed to your Dollar Bank during the prior year, or your account balance at the time the payments are issued less a minimum remaining balance of $150.

5. Life Insurance Benefit- <u>NOT</u> DEDUCTED FROM DOLLAR BANK

- Eligible participants are covered by a $30,000 insured death benefit