IBEW LOCAL UNION 351
WELFARE, PENSION, SURETY & WELFARE and 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 351 Welfare, Pension, Surety and Welfare 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 351 WELFARE FUND

Effective January 1, 2025

ELIGIBILITY RULES – ACTIVE EMPLOYEES

INITIAL ELIGIBILITY

You will become initially eligible for benefits on the first day of the second month following an employment period of not more than six consecutive months during which you have been credited with at least 300 hours of service. Upon satisfying this requirement, you will remain eligible for at least three months.

If You Have 300 Hours During the Prior:	You Will Become Eligible:	And Will Remain Eligible Until At Least:
June through November	January 1	May 31
July through December	February 1	May 31
August through January	March 1	August 31
September through February	April 1	August 31
October through March	May 1	August 31
November through April	June 1	November 30
December through May	July 1	November 30
January through June	August 1	November 30
February through July	September 1	February 28 (29)
March through August	October 1	February 28 (29)
April through September	November 1	February 28 (29)
May through October	December 1	May 31

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)

RESERVE HOURS

Hours of service in excess of the hours required to establish and maintain eligibility will be placed in a reserve (Reserve A) and will accumulate up to a maximum of 600 hours. This reserve 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. You will also receive 150 service hours credited to a reserve (Reserve B) for each full calendar year that you are eligible up to a maximum of 1,200 hours. This service hour reserve will be applied to maintain your eligibility upon your retirement or death. However, reserve hours may not be utilized to maintain your eligibility following your retirement if you continue to work at the trade for a signatory or non-signatory employer in a position not requiring contributions to the Welfare Fund.

DISABILITY CREDIT

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.

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 300 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 fourth month following your employment. Your eligibility will terminate on the last day of the month, which follows the month for which your employer last makes required contributions.

COBRA

If you fail to satisfy the above requirements and lose eligibility, you and your dependents may continue coverage under COBRA for up to 18 months (29 months if you are totally disabled). If your dependent loses eligibility due to your divorce or legal separation, or your child ceasing to satisfy the definition of an eligible dependent, they may continue coverage under COBRA for up to 36 months.

If your dependent child(ren) lose eligibility due to your death, they will remain eligible until the last day of a period of (12) months following the date of your death or to the extent that your reserve hours and service hours are sufficient to maintain your eligibility, whichever is longer. Upon completion of that period of time, they may continue coverage under COBRA for up to 36 months.

The current monthly self-pay rates for the full plan under COBRA are:

Single	$ 1,159.00
Parent/Child(ren)	$ 1,427.00
Family	$ 1,794.00

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 60 of the 80 quarters 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 Union 351 Pension Fund except if you have been eligible as a non-bargaining employee.
- You make the required contributions in the amount established by the Trustees after exhausting your accumulated Reserve Hours. If you have attained age 62, or are totally disabled, the required contribution is $200 per month. The required contribution for early retirees under age 62 is based upon the current monthly COBRA rates. Exception - if you retire on or after April 1, 2005 and after attaining age 58, and you do not elect the lump-sum form of payment under the IBEW Local 351 Pension Plan, the required contribution will be $200 per month after you attain age 60 rather than after you attain age 62.

The Supplemental Welfare Fund covers the medical, dental and prescription benefits of all retired Welfare Fund participants and their dependents.

The health insurance provided under the Supplemental Welfare Fund to retired Medicare eligible individuals is a Group Medicare Advantage PPO plan. This coverage provided by the Supplemental 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.

WAIVER OF RETIREE COVERAGE

In order to be eligible for coverage through the Supplemental Welfare Fund as a retired participant, you are required to make monthly contributions in amounts established by the Trustees. Some retirees are eligible for other group health insurance coverage through the employment of their spouse or their own employment. Retirees are allowed to temporarily waive their coverage under the IBEW Local 351 Supplemental Welfare Fund with a one-time opportunity (per lifetime) to re-enter the Plan on a subsequent January 1st. During the period of time that coverage is waived, no contributions will be collected. This waiver will apply to all dependents, not just the retired participant.

Please contact the Fund Office's Contribution Processing Department or visit www.ieshaffer.com for forms and more information regarding this **waiver**.

OPT-OUT OF MEDICARE ADVANTAGE AND/OR PRESCRIPTION PLAN FOR RETIREES

For each Medicare eligible retiree and/or Medicare eligible spouse of a retiree covered by the Plan, they will have the option to opt-out of the Medicare Advantage PPO Plan and/or Medicare Part D Prescription Drug Plan coverage. The retiree must continue to make the required contribution for the retiree benefits. There will be no reduction in the rate despite the opt-out selection. Retirees and their dependents are allowed to temporarily opt-out of their Medicare Advantage and/or Prescription coverage under the IBEW Local 351 Supplemental Welfare Fund with a one-time opportunity (per lifetime) to re-enter the Plan on a subsequent January 1st.

Please contact the Fund Office's Enrollment Department or visit www.ieshaffer.com for forms and more information regarding this **opt-out**.

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 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 (A & B 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. When participant dies while on COBRA, reserve B hours will be used.
2. The date your surviving spouse remarries.
3. The date your 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 active participants may continue coverage for an indefinite period of time at the current COBRA rates for themselves and/or your dependent children.

Surviving spouses of active participants may continue coverage for an indefinite period of time for $1,100 per month. In the case of a surviving spouse who is Medicare Primary, the monthly premium is $440. If there are dependent children, the surviving spouse may continue coverage under the COBRA rate for Parent/Child. 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 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 (A & B reserve hours) are sufficient to maintain your eligibility, whichever is longer. Widows are covered at no cost for this 12 month period. The date your surviving spouse remarries. The self-pay privilege ends at the end of the 36 month period or date of marriage, if later.
2. The date surviving spouse becomes eligible for other group coverage.

3. 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 coverage for an indefinite period of time at the current COBRA rates for themselves and/or your dependent children.

Surviving spouses of retired participants may continue coverage for an indefinite period of time for $1,100 per month. In the case of a surviving spouse who is Medicare Primary, the monthly premium is $440. If there are dependent children, the surviving spouse may continue coverage under the COBRA rate for Parent/Child. 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 351 WELFARE FUND

TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **LIFE INSURANCE**
  - Active employees only – $30,000
  - Active employees age 55 through 59 with at least 20 years pension credited service under the IBEW Local 351 Pension Plan - $280,000

- **ACCIDENTAL DEATH & DISMEMBERMENT -** Active employees only – $30,000

- **MEDICAL - HORIZON BLUE CROSS BLUE SHIELD OF NJ**
  Actives and Non-Medicare Eligible Retirees
  - 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
  - See following pages for plan information
  - Call Capital RX at 1-855-922-7794 for more information

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

- **VISION– HORIZON BLUE CROSS BLUE SHIELD OF NJ**
  Actives and Non-Medicare Eligible Retirees
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for more information

- **HEARING - HORIZON BLUE CROSS BLUE SHIELD OF NJ**
  Actives and Non-Medicare Eligible Retirees
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for more information

- **BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS - HORIZON BEHAVIORAL HEALTH**
  Actives and Non-Medicare Eligible Retirees
  - See following pages for plan information
  - Call Horizon Behavioral Health at 1-800-626-2212 24/7 for urgent clinical matters
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for claim & service inquiries.

- **THIS PLAN AND MEDICARE -** Medicare eligible participants (with the exception of those who are still either actively employed or the dependents of active employees) must enroll in Medicare Parts A and B. The retiree coverage provided by the Supplemental Welfare Fund requires Medicare eligible individuals to be enrolled in Medicare Parts A and B. The Supplemental Welfare Fund will enroll these individuals in its own Group Medicare Advantage Medical Plan and Medicare Part D Prescription Plan. (Your Dental coverage will be provided though the Welfare Fund – see note above).

  Your Medicare Coverage Includes:
    - **Group Medicare Advantage PPO Plan** for Medicare Eligible Retirees through RetireeFirst which covers:
      - Medical
      - Vision
      - Hearing
    - **Group Medicare Part D Prescription Plan** through RetireeFirst

  See following pages for plan details. Please call RetireeFirst at 1-866-302-7770 for more information.

IBEW LOCAL UNION 351 WELFARE FUND

BENEFITS
FOR

Active Employees
&
Non-Medicare
Eligible Retirees

IBEW LOCAL UNION 351 WELFARE FUND

SCHEDULE OF BENEFITS

Actives Employees and Non-Medicare Eligible Retirees

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY DIRECT ACCESS NETWORK with BlueCard
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	$3,300	not applicable
Family	$6,600	not applicable
CO-INSURANCE	100%	not covered
LIFETIME MAXIMUM	unlimited	not applicable
DOCTOR'S OFFICE VISITS		
Primary Care Office Visit	100% after $15 co-pay	not covered
Specialist Office Visit	100% after $15 co-pay	not covered
Maternity Visits	100% after $15 co-pay (applies to 1st visit only)	not covered
Urgent Care	100% after $15 co-pay	not covered
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. $15 co-pay if performed in doctor's office.

	IN-NETWORK	OUT-OF-NETWORK
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 care requires prior authorization		
EMERGENCY CARE		
Emergency Room	100% after $100 copay	100% after $100 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 $15 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 $15 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 $15 co-pay	not covered
*Up to 30 visits per person per calendar year		
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.		

	IN-NETWORK	OUT-OF-NETWORK
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 $15 co-pay	not covered
Physical Therapy	100% after $15 co-pay	not covered
Respiratory Therapy	100% after $15 co-pay	not covered
Speech Therapy	100% after $15 co-pay	not covered
*50 visits per person per calendar year		
All Other Covered Medical Services	100% coverage	not covered

Prior Authorization Requirements

All providers will need prior authorization for the following services/procedures:

Inpatient Facility Care

- All in-patient facility stays must receive prior authorization BY **HORIZON BLUE CROSS BLUE SHIELD / HORIZON BEHAVIORAL HEALTH (Horizon) at least 24 hours prior to admission**. Emergency admissions must be authorized within 72 hours after hospital admission. Benefits may be reduced if prior authorization is not obtained.

Outpatient Services

- Home health care, intensive outpatient and sub-acute partial hospitalization stays require prior authorization by **Horizon**.

Air Ambulance (retroactive)

Gastric Bypass Procedures

Therapy/Testing Services
The following procedures must receive prior authorization from **Evicore/TurningPoint**:

Diagnostic Radiology:
- Advanced Imaging (e.g. CT scan, CTA, CCTA, MRA, MRI, Nuclear Medicine, PET Scans)

Musculoskeletal:
- Intervention Pain Management (e.g. Epidural Injections)
- Spine Surgery (e.g. Decompressions and Fusions)

Cardiology:
- Advanced Imaging and Diagnostic Services (e.g. Stress Test, Echocardiogram, CT, MRI)
- Implantable Device Services (e.g. Pacemaker, Implantable Defibrillator)

Radiation Therapy:
- External Beam Radiation Therapy
- Brachytherapy
- Intensity Modulated Radiation Therapy
- Image Guided Radiation Therapy
- Stereotactic Radiosurgery
- Proton Therapy
- Tomotherapy
- Radiopharmaceuticals

Your doctor's office will work directly with Horizon, Evicore/TurningPoint to obtain prior authorizations when applicable.

In-Network Only

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

How to Find a HORIZON Blue Cross Blue Shield of NJ Healthcare Provider

- Visit www.HorizonBlue.com and click on "Find a Doctor" at the top of the page. Then look for "Not a member" at the bottom of the next page. Select "Find Care in NJ" if within NJ. Enter "Direct Access" as your Plan and enter your location or browse by category. If outside NJ, click on "Find Care Outside NJ" and select "BCBS PPO" as your plan and enter location or browse by category
- Call I.E. Shaffer & Co. at 1-800-792-3666
- Confirm with your treating physician, hospital, lab or other provider prior to services.

Horizon Care Navigator

(Available to Active and Retired Non-Medicare Eligible Participants and Covered Dependents)

If you have an acute or chronic condition, or need help understanding a new diagnosis, your dedicated Horizon Blue Cross Blue Shield Care Navigator, who is a **Registered Nurse**, can help by:

- Monitoring your medical situation and working with your doctors and caregivers to help manage your health needs
- Talking to you about your health and possible ways to improve it
- Connecting you with other health professionals, including registered dietitian and behavioral health specialist.

Participation in the program is free and voluntary. To speak with your Horizon Care Navigator, call **1-888-621-5894**, option **2**, followed by option **3** weekdays, between 8am and 5pm Eastern Time.

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 never 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.

When balance billing isn’t allowed, you also have these protections:

- 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 *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

IBEW Local Union 351 Welfare Fund
PRESCRIPTION DRUG BENEFIT
Active Employees and Non-Medicare Eligible Retirees
Please call CAPITAL RX at 1-855-922-7794 for more information

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

- Generic Drugs – $10 co-payment
- Preferred Brand Name Drugs – 20% of the cost of the medication, $100 maximum
- Non-Preferred Brand Name Drugs – 20% of the cost of the medication, no maximum

Maximum **90-day** supply

- Generic Drugs - $20 co-payment
- Preferred Brand Name Drugs – 20% of the cost of the medication, $200 maximum
- Non-Preferred Brand Name Drugs – 20% of the cost of the medication, no maximum

Insulin co-payments

- 30-day supply of Preferred and Non-Preferred Brands - $20 co-payment
- 90-day supply of Preferred and Non-Preferred Brands - $40 co-payment

100% co-payment for all brand name PPI medications including Aciphex, Nexium, Zegrid, Prevacid and Protonix

Specialty Medication
- Preferred Brand Name – 20% of the cost of the medication, $200 maximum

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After $3,300 per person or $6,600 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).

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 – ***All Active Employees and Retirees***

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

1st option: **DELTA DENTAL**

- Annual Deductible - $50/person or $150/family
- Preventative and diagnostic services – 100% after deductible
- Basic services – 80% after deductible
- Major services – 50% after deductible
- Orthodontia services – 50%
- Annual Dental Maximum - $3,000/family (not including orthodontia)
- Lifetime Dental Orthodontia Maximum - $2,000/person

Oral Health Enhancement Option – provides additional benefits for eligible participants with periodontal (gum) disease

- Must have claims history or submit evidence of having periodontal surgery or scaling and root planning.

- Those who have been previously treated for periodontal disease will receive up to four dental cleanings and/or periodontal maintenance procedures per benefit period

Carryover Max Benefits – allows eligible participants to carry over part of their unused standard annual maximum in one year to increase benefits for the following year and beyond. Eligible participants must meet the following criteria to qualify for Carryover Max benefits:

- Covered by the Welfare Fund on January 1st of a year to carry over into the following year,

- Use no more than 50% of the annual maximum during the benefit year, and

- See a dentist during the benefit year for an oral exam or cleaning and submit a claim for these services. If a claim for an exam or cleaning is not received, any accumulated Carryover Max benefit will be lost.

  Participants meeting these criteria can accumulate 25% of the unused annual maximum. Participants continuing to accumulate benefits can eventually have twice the annual maximum available, however, the accumulated amount can never exceed the annual maximum amount.

Carryover Max Limitations:

- Annual Dental Maximum: $3,000
- Usage Limit: $1,500 (50% of annual maximum)
- Accumulation Limit: $750 (25% of annual max)
- Carryover Max accumulated amount cannot exceed $3,000

OR

2nd option: **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 annual 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

VISION BENEFIT– *All Active Employees, Non-Medicare Eligible Retirees or Non-Medicare Eligible Spouses of Retirees*

Adults (over 19 years old):

Routine vision screening per person per calendar year	100% after $15 co-pay
Frames/lenses or contact lenses per person per calendar year	Up to $400

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

HEARING BENEFIT– *All Active Employees and Non-Medicare Eligible Retirees or Non-Medicare Eligible Spouses of Retirees*

Hearing Aid and Exam 100% coverage

- Unlimited benefit up to age 15.
- Up to $2,000 per person for age 15 and older
- Maximum benefit payable once every 36 months

IBEW LOCAL UNION 351 WELFARE FUND

Actives and Non-Medicare Eligible Retirees

BENEFIT PLAN MAXIMUMS

Annual Delta Dental Maximum - $3,000 per family

Annual DSO Dental Plan Maximum – unlimited

Annual In-Network Medical Maximum Out-of-Pocket Limit-$3,300 person/$6,600 family
(Co-pays, deductibles and co-insurance count towards this out-of-pocket limit)

Annual Prescription Maximum Out-of-Pocket Limit - $3,300 person/$6,600 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

Medical expenses exceeding $250,000 per accident that occur while operating or riding on a motorcycle, scooter, dirt bike or all-terrain vehicle will not be covered

Hearing Aids – Unlimited benefit up to age 15. Up to $2,000 per person every 36 months for age 15 and older

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 Orthodontia Maximum - $2,000/person

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

Speech Therapy Maximum – 50 visits per person per calendar year

IBEW LOCAL 351 SUPPLEMENTAL WELFARE FUND

BENEFITS
FOR

MEDICARE ELIGIBLE RETIREES

IBEW LOCAL UNION 351 SUPPLEMENTAL WELFARE FUND

SCHEDULE OF BENEFITS

Medicare Eligible Retirees & Medicare Eligible Spouses of Retirees

Aetna Medicare Advantage PPO Plan

Effective Date: January 1, 2024

Please call RETIREEFIRST at 1-866-302-7770 with any questions about your Aetna Medicare Advantage PPO Plan

Medical	You pay
Deductible	$0
Office Visit: Primary Care	$0
Office Visit: Specialist	$0
Therapy (Occupational/Physical/Speech)	$0
Inpatient Hospital	$0
Outpatient Care	$0
Home Health Care	$0
Skilled Nursing Facility	$0 (Days 1-120)
Emergency Room	$0
Urgent Care	$0
Ambulance Services	$0 (Medicare-approved)
Lab Services	$0
Radiology Services	$0

Durable Medical Equipment	$0
Preventative Screenings	$0
Private Duty Nursing	$0 (120 Visits per year maximum)
Chiropractic	$0 (30 Visits per year)
Acupuncture	$0 (30 Visits per year)
Podiatry	$0 (6 Visits per year)
Hearing	$0 Routine hearing exam every 12 months $3,000 Hearing aid reimbursement every 36 months
Vision	$0 Routine eye exam every 12 months $500 Eyewear reimbursement every 12 months
Foreign Travel (World-wide) Coverage	$0 Emergency room & urgently needed care
Fitness Benefit	SilverSneakers®
Additional Covered Services	$0 Compression stockings $0 Foot orthotics $0 Transportation service (Up to 24 times per year within 60 miles per trip) $400 Annual allowance for wigs Meal delivery following hospitalization (up to 14 meals)

- You must <u>continue</u> to be enrolled in Medicare Parts A and B and pay for Part B premium to participate in the **Aetna Medicare Advantage PPO** plan. The retiree coverage provided by the Supplemental Welfare Fund requires Medicare eligible individuals to be enrolled in Medicare Parts A and B.
- If your provider accepts Medicare, the portion you are responsible for will remain the same whether your provider is in or out of the Medicare Advantage network. You may go to any willing Medicare provider, hospital or facility. Please call RetireeFirst at 1-866-302-7770 for assistance.
- Present your new Aetna ID Card **only** for Medical services. Keep your Medicare Card in a safe place.

IBEW LOCAL UNION 351 SUPPLEMENTAL WELFARE FUND
PRESCRIPTION DRUG BENEFIT

For 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 - $10 co-payment
- Preferred Brand Name Drugs – $20 co-payment
- Non-Preferred Brand Name Drugs – $40 co-payment

Maximum **90-day** supply

- Generic Drugs - $25 co-payment
- Preferred Brand Name Drugs- $50 co-payment
- Non-Preferred Brand Name Drugs- $100 co-payment

Mail Order Prescriptions

Group Medicare Part D Plan from RetireeFirst

Maximum **90-day** supply

- Generic Drugs – $25 co-payment
- Preferred Brand Name Drugs – $50 co-payment
- Non-Preferred Brand Name Drugs –$100 co-payment

Specialty Drugs

Group Medicare Part D Plan from RetireeFirst

- 20% co-payment, $50 maximum

DENTAL BENEFIT

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

<u>1st option</u>: **DELTA DENTAL**

- Annual Deductible - $50/person or $150/family
- Preventative and diagnostic services – 100% after deductible
- Basic services – 80% after deductible
- Major services – 50% after deductible
- Orthodontia services – 50%
- Annual Dental Maximum - $3,000/family (not including orthodontia)
- Lifetime Dental Orthodontia Maximum - $2,000/person

Oral Health Enhancement Option – provides additional benefits for eligible participants with periodontal (gum) disease

- Must have claims history or submit evidence of having periodontal surgery or scaling and root planning.

- Those who have been previously treated for periodontal disease will receive up to four dental cleanings and/or periodontal maintenance procedures per benefit period

Carryover Max Benefits – allows eligible participants to carry over part of their unused standard annual maximum in one year to increase benefits for the following year and beyond. Eligible participants must meet the following criteria to qualify for Carryover Max benefits:

- Covered by the Welfare Fund on January 1st of a year to carry over into the following year,

- Use no more than 50% of the annual maximum during the benefit year, and

- See a dentist during the benefit year for an oral exam or cleaning and submit a claim for these services. If a claim for an exam or cleaning is not received, any accumulated Carryover Max benefit will be lost.

Participants meeting these criteria can accumulate 25% of the unused annual maximum. Participants continuing to accumulate benefits can eventually have twice the annual maximum available, however, the accumulated amount can never exceed the annual maximum amount.

Carryover Max Limitations:

- Annual Dental Maximum: $3,000
- Usage Limit: $1,500 (50% of annual maximum)
- Accumulation Limit: $750 (25% of annual max)
- Carryover Max accumulated amount cannot exceed $3,000

OR

2nd option: **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 annual 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

IBEW LOCAL UNION 351 PENSION FUND

Effective January 1, 2022

IMPORTANT TERMS

- Plan Year - January 1st to December 31st
- Credited Service
- For service after 1/1/96, 1/12th year of credit for each 100 hours of service up to a maximum of 1 year of credit for 1,200 hours.
- For service from 10/1/95 to 12/31/95, 1/12th year of credit for each 100 hours of service up to a maximum of .25 year of credit for 300 hours.
- For service prior to 10/1/95, credit is based upon provisions of prior plans 211, 439 and 592.
- Vested Service - 1 year of credit for 1,000 hours of service (no partial credit).
- Vesting - 100% after 5 years vested service if employed after 1/1/99.
- Forfeiture - occurs if prior to becoming vested you incur a period of at least 5 consecutive 1 year breaks in service, which equals or exceeds your vested service.
- Break in Service - any plan year during which you do not earn any credited service.

TYPES OF PENSION BENEFITS

- Normal Retirement – payable at age 60 with 10 years of credited service or age 62 with 5 years of participation.
- Early Retirement – payable at age 55 if vested.
- Disability Retirement – payable at any age, with Social Security Disability, and 8 years of credited service.

NORMAL RETIREMENT BENEFITS

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

- $1.10 per month for each full $50 of contributions from 10/1/95 to 12/31/98, plus,
- $1.00 per month for each full $50 of contributions from 1/1/99 to 12/31/02, plus,
- $1.00 per month for each full $100 of contributions from 1/1/03 to 12/31/04, plus,
- $1.00 per month for each full $110 of contributions from 1/1/05 to 12/31/05, plus,
- $1.00 per month for each full $135 of contributions from 1/1/06 to 12/31/06, plus,
- $1.00 per month for each full $180 of contributions from 1/1/07 to 12/31/07, plus,
- $1.00 per month for each full $200 of contributions from 1/1/08 to 12/31/09, plus,
- $1.00 per month for each full $210 of contributions from 1/1/10 to 12/31/10, plus,
- $1.00 per month for each full $220 of contributions from 1/1/11 to 12/31/18, plus,
- $1.00 per month for each full $200 of contributions from 1/1/19 to 12/31/20, plus
- $1.00 per month for each full $175 of contributions from 1/1/21 to 12/31/21, plus
- $1.00 per month for each full $150 of contributions after 1/1/22, plus
- 110% of the monthly benefit earned under the Local 211, 439 and 592 Pension Plans.

EARLY RETIREMENT BENEFITS

Same as Normal Retirement amount reduced by 1/2% for each month that you retire prior to age 60 and 1/3% for each month that you retire prior to age 56. For example, at age 58 your benefit would be reduced by 12%. At age 56 your benefit would be reduced by 24%. At age 55 your benefit would be reduced by 28%. There is no reduction in your benefit if the total of your age last birthday and years of credited service is at least 83 ("Rule of 83"). Plus, a supplement payable until age 62 for employees with at least 20 years of credited service equal to your early retirement benefit determined above. Participants who select a lump sum form of payment are not eligible for an Early Retirement supplement.

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
- Life Annuity with 120 payments guaranteed
- Life Annuity with 180 payments guaranteed
- Life Annuity with 240 payments guaranteed
- Spouse's Joint and 50%, 75% or 100% to Survivor (with pop-up)
- Lump sum (for benefit accrued through 12/31/02)

PRE-RETIREMENT DEATH BENEFITS

Non-Vested Employee With 2 But Less than 5 Years of Credited Service – (including 2 years during the 5 years prior to death)

- Lump sum benefit equal to $1,000 times years of credited service.

Non-Vested Employee With 5 But Less than 10 Years of Credited Service – (including 2 years during the 5 years prior to death)

- Lump sum benefit equal to 30 times your accrued normal retirement monthly benefit.

Vested Employee

- Lifetime benefit payable to your spouse equal to ½ your accrued normal retirement monthly benefit. This benefit commences immediately provided you

are over age 50 or have at least 20 years of credited service, or when you would have attained age 50 if you have less than 20 years of credited service, or
    - Lump sum benefit equal to 60 times your accrued normal retirement monthly benefit.

POST RETIREMENT DEATH BENEFITS

- Continuation of monthly benefit based upon form of payment elected at retirement.

IBEW LOCAL UNION 351 SURETY FUND

Effective July 1, 2019

YOUR ACCOUNT BALANCE IS EQUAL TO:

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

TYPES OF SURETY BENEFITS

- Retirement – payable if age 55 and retired from the Industry.
- Disability – payable if totally and permanently disabled.
- Full Termination – payable if no covered employment over 3 consecutive months.
- Partial Termination – 25% of your account balance payable if no covered employment over 15 consecutive days, but not more than two times in a calendar year.
- Death - payable upon death.
- Financial Hardship - available to participants for the following purposes:
    - Medical expenses of at least $500 incurred by you, your spouse, dependent child, parent or grandchild that have not been reimbursed by insurance.
    - Educational expenses for yourself, your spouse or dependent child to attend an educational institution above the high school level or a school for handicapped children.
    - Purchase of a home, cooperative or condominium apartment for your principal residence for which you have incurred down payment, contract or title expenses.
    - Funeral expenses incurred due to the death of your spouse, child or parent.
    - Home improvement of at least $5,000 or to prevent foreclosure or eviction from principal residence.

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

- Surety 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 351 SURETY FUND INVESTMENT OPTIONS:

Specialty
- Principal Real Estate Securities

Small Cap Fund
- Vanguard Small Cap Index

Mid Cap Funds
- Vanguard Mid Capitalization Index
- Eaton Vance Atlanta Capital SMID-Cap

Large Cap Funds
- BlackRock Equity Dividend
- Fidelity ContraFund
- J.P. Morgan Large Cap Growth
- Vanguard Dividend Appreciation Index
- Vanguard Institutional Index

International
- Artisan International Value
- Vanguard Developed Markets Index

Fixed Income
- SAGIC Core Bond II

Bond Fund
- MassMutual Diversified Bond

Balanced Fund
- Vanguard Balanced Index

Asset Allocation
- American Funds Target Date Retire - 2010,2015, 2020, 2025, 2030, 2035, 2040, 2045, 2050, 2055 and 2060

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 351 WELFARE & SUPPLEMENTAL FUND

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Effective: September 1, 2020

The IBEW Local 351 Welfare and Supplemental Fund has a Health Reimbursement Arrangement (HRA). The HRA is available to all collectively bargained active and retired participants who are eligible for benefits from the Welfare Fund. HRA accounts are funded annually each October by the Trustees of the Supplemental Welfare Fund based up the receipts received in the prior 12 months from the HRA employer contribution.

The HRA can be used for the reimbursement of eligible medical and dental expenses for participants and their dependents as detailed in IRS Publication 502 "Medical and Dental Expenses" which can be found at www.irs.gov/publications/p502/index.html. HRA participants are issued debit cards which can be used to pay for eligible HRA expenses. Eligible HRA participants also have the ability to submit paper claims to the Fund Office for HRA reimbursement.