IBEW LOCAL UNION 400 WELFARE, PENSION & ANNUITY FUNDS

QUICK REFERENCE GUIDE

FOR TIER II EMPLOYEES

EFFECTIVE: JANUARY 1, 2025

Important Notice: This is an outline of the principal plan provisions of the I.B.E.W. Local Union 400 Welfare, Pension and Annuity Plans and is not intended to completely describe the Plan provisions. In the event of any discrepancy between this outline and the Plans, the Plan Documents shall govern. For further information, please review your Summary Plan Description or contact the office of the Administrator, I. E. Shaffer & Co., at P. O. Box 1028, Trenton, NJ 08628. Telephone 1-800-792-3666.

IBEW LOCAL 400 TIER II

QUICK REFERENCE GUIDE

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This Quick Reference Guide also appears on the I.E. Shaffer & Co. website. Go to *www.ieshaffer.com*. Click on gray *"Log in"* box at the top of the page. Then click on "*IBEW Local 400"*. At the top of next page, move cursor to "*Guides & Reports*". A menu will appear and then click on "*Tier II*" under Quick Reference Guides.

IBEW LOCAL UNION 400 WELFARE FUND – TIER II

Effective January 1, 2025

ELIGIBILITY RULES – ACTIVE EMPLOYEES

INITIAL ELIGIBILITY

You will become eligible for Tier I benefits on the first day of the month that follows an employment period of not more than 3 consecutive months during which you have been credited with 440 hours of service provided your employment has been in a category contributing at the "A" rate for journeymen electricians. If your employment has been in a category contributing at less than the "A" rate for journeymen electricians, you will be eligible for Tier II benefits. Upon satisfying this requirement, you will remain eligible for at least three months.

You Will Become	If You Have
Eligible On:	**440 Hours During the Prior:**
January 1	October through December
February 1	November through January
March 1	December through February
April 1	January through March
May 1	February through April
June 1	March through May
July 1	April through June
August 1	May through July
September 1	June through August
October 1	July through September
November 1	August through October
December 1	September through November

CONTINUED ELIGIBILITY AND TERMINATION

To continue your eligibility after satisfying the initial requirement, you must have at least 320 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 320 hours.

Your Eligibility Will Terminate On:	**If You Do Not Have 320 Hours During the Preceding:**
February 28	October through December
May 31	January through March
August 31	April through June
November 30	July through September

REINSTATEMENT

Should your eligibility terminate, it will be reinstated provided you are credited with at least 320 hours of service during a calendar quarter which ends within 10 months after your eligibility terminated. Hours of service worked during the calendar quarter immediately preceding your termination date, plus any accumulated bank hours, will be applied towards this 320 hour requirement. Your eligibility will reinstate on the first day of the second month following that calendar quarter during which you meet this 320 hour requirement. If you do not satisfy this reinstatement provision, you will be treated as a new employee and will be subject to the 440 hour requirement for initial eligibility outlined above.

Termination Date:	**Period of Time to Work a Total of 320 Hours (Plus any Remaining Bank 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 320 hour requirement.

If You Are Credited with Your Required 320th 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

BANK HOURS

Hours of service in excess of 400 during a calendar quarter will be placed in a bank and will accumulate up to a maximum of 1,000 hours. This bank will be drawn upon to maintain your eligibility if you should fail to receive credit for at least 320 hours of service during a subsequent calendar quarter provided you are available for work under a Local 400 Collective Bargaining Agreement requiring contributions to this Fund. Participants who qualify for retiree Welfare Fund coverage will utilize up to 640 of their accumulated bank hours to maintain their eligibility prior to making required monthly retiree contributions.

DISABILITY CREDIT

After having satisfied the eligibility requirements, if you are totally disabled and unable to work as an electrician because of illness or injury, your eligibility will be continued for as long as you remain totally disabled but not more than 24 months. To be considered totally disabled, you must be under the care of a legally qualified physician and supply proof that you continue to be totally disabled with such proof required at reasonable intervals by the Plan.

UPGRADE TO TIER I BENEFITS

As of January 1st of each year, if you are eligible for Tier II benefits but not for Tier I benefits, you may elect to make additional contributions on your own behalf so as to qualify for Tier I benefits for the remainder of that calendar year. The required additional contribution to qualify for Tier I benefits is equal to $31,240 less the employer contributions actually made on your behalf to the combination of the Welfare Fund and the Auxiliary Welfare Fund for the immediately preceding calendar year. Each year the Fund Office will provide a general notice to each employee covered under Tier II advising them of their right to upgrade to Tier I. If Tier I coverage is desired, you may

request an exact calculation of the amount due and the required additional contribution must be paid within 30 days of your being notified by the Fund Office.

DOWNGRADE TO TIER II BENEFITS

If you are covered under Tier I and accept employment in a category contributing less than the "A" rate for journeymen electricians, your coverage will be reduced to Tier II on the first day of the month following three consecutive months of such employment. Coverage will be restored to Tier I on the first day of the month following three consecutive months of employment in a category contributing at the "A" rate for journeymen electricians.

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.

CONTINUATION UNDER 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 death, 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. The current monthly rates for the Tier II plans under COBRA are:

Family	$1,012.50
Parent/Child(ren)	$ 759.38
Single	$ 506.25

If your spouse loses eligibility due to your death, self-pay continuation of coverage is available for an indefinite period of time at the following rates:

Parent/Child(ren)	$508.00
Single	$339.00

ELIGIBILITY RULES – RETIRED EMPLOYEES

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

- You are eligible as an active employee at the time of your retirement.
- You have attained age 55 or are totally and permanently disabled.
- You have earned at least 25 years of Credited Service under the IBEW Local Union 400 Pension Plan (15 years if you are receiving a disability retirement pension benefit), with at least 5 years of Credited Service earned during the 10 plan years immediately preceding your retirement (not applicable to non-bargaining employees).
- Please note while it is possible to earn more than one year of Pension Fund Credited Service in a Plan year (that begins April 1 and ends the following March 31), a maximum of only 1 year of Credited Service per Plan Year will count towards the Credited Service requirements in the three Welfare Fund eligibility rules above
- You will be eligible for Tier I benefits provided you have been eligible for Tier I benefits as an active employee for at least 20 of the 40 quarters immediately preceding your retirement. Otherwise, you will be eligible for Tier II benefits.
- You make the required contributions in the amount established by the Trustees following your termination from Active coverage. Participants who retire from the Pension Fund on or after 4/1/20, who qualify for retiree Welfare Fund coverage, will utilize up to 640 of their accumulated bank hours to maintain their eligibility prior to making required monthly retiree contributions.
- If you qualify for Tier I benefits and have not attained age 62, the required contribution is $800 per month. Between the age of 62 and 64, the required contribution for Tier I benefits is 15% of your monthly pension, up to a maximum of $300 per month. After attaining age 65, the required contribution for Tier I benefits is equal to 10% of your monthly pension benefit up to a maximum of $200 per month. If you qualify for Tier II benefits and have not attained age 62, the required contribution is $540 per month. Between the age of 62 and 64, the required contribution for Tier II benefits is 15% of your monthly pension, up to a maximum of $300 per month. After attaining age 65, the required contribution for Tier II benefits is equal to 10% of your monthly pension benefit up to a maximum of $200 per month. If you fail to make the required contributions at any time, you will not be able to reinstate your eligibility for benefits on a later date.

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

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

COVERAGE FOR DEPENDENT CHILDREN OF RETIREES

Single or married retirees with dependent children under the age of 26 must pay an additional $675 per month to cover one or more of their dependent children.

WAIVER OF RETIREE COVERAGE

In order to be eligible for coverage through the 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 and surviving spouses are allowed to temporarily waive their coverage under the IBEW Local Union 400 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. Please contact the Fund Office for more information regarding this waiver. 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 Union 400 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 (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 6 months following your death or to the extent that your bank hours are sufficient to maintain your eligibility, whichever is longer. Surviving spouses and dependent children are covered at no cost for this 6-month period.
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 for themselves and/or dependent children. The current rates are as follows:

Single	Tier I $452	Tier II $339
Parent/Child	Tier I $678	Tier II $508

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 dependent children surviving (no spouse) after the 6 months of guaranteed coverage, the dependent children would be able to continue the coverage for up to 36 additional months under COBRA.

The rate for spouses who elect Single Coverage and who have primary coverage from Medicare is $339.

Spouse and dependent children of a participant who was <u>RETIRED</u> (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 6 months following your death or to the extent that your bank hours are sufficient to maintain your eligibility, whichever is longer. Your surviving spouse and dependent children are covered at no cost for this 6 month period.
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 retired participants may continue coverage for an indefinite period of time for themselves and/or dependent children.

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IBEW LOCAL UNION 400 WELFARE FUND – TIER II

TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **LIFE INSURANCE**
  - Active employees – $20,000
  - Retired employees - $2,000

- **ACCIDENTAL DEATH AND DISMEMBERMENT**
  - Active employees - $20,000
  - Retired employees - $2,000

- **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 – EXPRESS SCRIPTS**
  Actives and Non-Medicare Eligible Retirees
  - See following pages for plan information
  - Call Express Scripts at 1-866-759-1560 for more information

- **DENTAL – YOUR CHOICE OF PROVIDER OR DENTAL SERVICES ORGANIZATION (DSO)**
  - 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 retired 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 Welfare Fund requires Medicare eligible individuals to be enrolled in Medicare Parts A and B. The 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 400 WELFARE FUND – TIER II

BENEFITS
FOR

Active Employees
&
Non-Medicare Eligible Retirees

IBEW LOCAL UNION 400 WELFARE FUND – TIER II

SCHEDULE OF BENEFITS

Active 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	$2,500	not applicable
Family	$5,000	not applicable
LIFETIME MAXIMUM	unlimited	not applicable
DOCTOR'S OFFICE VISITS		
Primary Care Office Visit	80% coverage	not covered
Specialist Office Visit	80% coverage	not covered
Maternity Visits	80% coverage	not covered
Urgent Care	80% coverage	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. 80% coverage if performed in doctor's office.

	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL CARE		
Inpatient Admission	100% coverage	not covered
Inpatient Physician Services	80% coverage	not covered
Surgery in Hospital	80% coverage	not covered
Outpatient Hospital Services	80% coverage	not covered
* Inpatient hospital care requires prior authorization		
EMERGENCY CARE		
Emergency Room	80% after $100 copay	80% after $100 copay
*This copay is waived if admitted		
Ambulance	80% coverage	80% coverage
*Covers transport if emergent and medically necessary		
OUTPATIENT SURGERY		
Hospital Outpatient Surgery	80% coverage	not covered
Surgery in Ambulatory SurgiCenter	80% coverage	not covered
BEHAVIORAL HEALTH		
Office Visit	80% coverage	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	80% coverage	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	not covered	not covered
Home Health Care Services	80% coverage	not covered
*Maximum 200 visits per calendar year, 4 hours=1 visit, no custodial care. Prior Authorization required.		
Hospice Services	80% coverage	not covered
*Maximum 200 visits per calendar year, 4 hours = 1 visit. Excludes respite care, pastoral care and counseling.		
Skilled Nursing Care		
Inpatient	100% coverage	not covered
Outpatient (at home)	80% coverage	not covered
Outpatient (at facility)	100% coverage	not covered
*Maximum 120 days per calendar year. Medical treatment only.		

	IN-NETWORK	OUT-OF-NETWORK
THERAPY SERVICES		
Occupational Therapy	80% coverage	not covered
Physical Therapy	80% coverage	not covered
Respiratory Therapy	80% coverage	not covered
Speech Therapy *50 visits per person per calendar year	80% coverage	not covered
All Other Covered Medical Services	80% 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 400 WELFARE FUND – TIER II

PRESCRIPTION DRUG BENEFIT

Active Employees and Non-Medicare Eligible Retirees

Please call EXPRESS SCRIPTS at 1-866-759-1560 for more information

Participating Retail Pharmacy

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

- Generic Drugs – $3 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $150 maximum
- Non-Preferred Brand Name Drugs – 50% co-payment

After $4,100 per person or $8,200 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.

Mail Order Prescriptions

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

- Generic Drugs – $6 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $300 maximum
- Non-Preferred Brand Name Drugs – 50% co-payment

After $4,100 per person or $8,200 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.

Specialty Medication

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

There is an annual co-payment limit is $2,500 for specialty medications

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*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:

Dental Services Organization (DSO) dental plan under which all treatment is be 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

OR

In lieu of the DSO dental plan, participants may elect on an annual basis the standard dental plan with benefits payable at 100%, up to an annual maximum of $880/family. Orthodontia counts towards this dental maximum.

IBEW LOCAL UNION 400 WELFARE FUND – TIER II

Actives and Non-Medicare Eligible Retirees

BENEFIT PLAN MAXIMUMS

Annual DSO Dental Plan Maximum – unlimited

Annual In-Network Medical Maximum Out-of-Pocket Limit-$2,500 person/$5,000 family
(Co-pays, deductibles and co-insurance count towards this out-of-pocket limit)

Annual Prescription Maximum Out-of-Pocket Limit - $4,100 person/$8,200 family
(Prescription co-pays count towards this limit)
For active employees and non-Medicare eligible retired employees only

Annual Standard Dental Plan Maximum - $880 per family

Standard Orthodontia Maximum - $880 per family (counts towards annual standard dental maximum)

Chiropractic Care Maximum – 30 visits per person or 40 visits per family per year

Home Health Care Maximum - 200 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

Medical Benefit Lifetime Benefit - unlimited

Motor Vehicle Exclusion – no coverage for medical expenses arising due to an automobile or other motor or recreational vehicle related accident (e.g. automobiles, motorcycles, jet skis, all-terrain vehicles, etc.)

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

Speech Therapy Maximum – 50 visits per person per calendar year

IBEW LOCAL UNION 400 WELFARE FUND – TIER I

BENEFITS
FOR

MEDICARE ELIGIBLE RETIREES

IBEW LOCAL UNION 400 WELFARE FUND – TIER II

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 Unlimited visits
Podiatry	$0 Unlimited visits
Hearing	$0 Routine hearing exam every 12 months
Vision	$0 Routine eye exam every 12 months $300 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 continue 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 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 Aetna ID Card **only** for Medical services. Keep your Medicare Card in a safe place.

IBEW LOCAL UNION 400 WELFARE FUND – TIER II
PRESCRIPTION DRUG BENEFIT
Medicare Eligible Retirees & Medicare Eligible Spouses of Retirees

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 - $3 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $150 maximum
- Non-Preferred Brand Name Drugs – 50% co-payment

Maximum 90-day supply

- Generic Drugs - $6 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $300 maximum
- Non-Preferred Brand Name Drugs – 50% co-payment

Mail Order Prescriptions

Group Medicare Part D Plan from RetireeFirst

Maximum 90-day supply

- Generic Drugs – $6 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $300 maximum
- Non-Preferred Brand Name Drugs –50% co-payment

Specialty Medication

Group Medicare Part D Plan from RetireeFirst

- 20% co-payment, max. $200 maximum

DENTAL BENEFIT – All Active Employees and Retirees

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

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

- No deductible
- No annual benefit maximum
- added
- 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

OR

In lieu of the DSO dental plan, participants may elect on an annual basis the standard dental plan with benefits payable at 100%, up to an annual maximum of $880/family. Orthodontia counts towards this dental maximum.

IBEW LOCAL UNION 400 WELFARE FUND
HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The IBEW Local 400 Welfare Fund has a Health Reimbursement Arrangement (HRA). The HRA is available to all employees who are eligible for benefits from the Welfare Fund.

- Each eligible employee's HRA account is funded by contributions equal to 2% of gross wages. Please note that this contribution rate is subject to change based on approvals.

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. Retired participants may use their HRA to make their required contribution for benefits up until age 65 when they become eligible for Medicare. 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.

IBEW LOCAL UNION 400 PENSION FUND

Effective April 1, 2021

IMPORTANT TERMS

- Plan Year - April 1st to March 31st
- Credited Service
  - For service after 4/1/21, 1/10th of a year of Credited Service for each 100 hours of service in a Plan Year up to a maximum of 1 year of Credited Service for 1,000 hours. Plus, 1/10th of a year of Credited Service for each 100 hours worked beyond 1,400 hours in a Plan Year, up to a maximum of an additional 1/2 of a year of Credited Service, for a total of 1.50 years of Credited Service, for 1,900 hours worked in a Plan Year. Under this provision, a participant who works 1,500 hours or more per Plan Year will earn Credited Service as outlined below:

Hours Worked in 1 Plan Year	Credited Service Earned
100	0.1
200	0.2
300	0.3
400	0.4
500	0.5
600	0.6
700	0.7
800	0.8
900	0.9
1,000	1.0
1,000 – 1,400	1.0
1,500	1.1
1,600	1.2
1,700	1.3
1,800	1.4
1,900 or more	1.5

  - For service from 4/1/69 to 3/31/19, 1/10th of a year of credit for each 100 hours of service up to a maximum of 1 year of credit for 1,000 hours.
  - For service from 4/1/61 to 3/31/69, 1 year of credit for each plan year that you were credited with at least 500 hours.
  - For service from 2/1/62 to 3/31/69 under Local 516, 1/10th of a year of credit for each 100 hours of service up to a maximum of 1 year of credit for 1,000 hours.

- For service prior to 4/1/61 (or 2/1/62 in the case of Local 516), 1 year of credit for each plan year that you were employed under the Union.

- 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 at least 5 consecutive 1 year breaks in service which in total equal or exceed your vested service.
- Break in Service - any plan year during which you do not earn at least 1/2 of a year of credited service.

TYPES OF PENSION BENEFITS

- Normal Retirement – payable at age 65 and 5 years of participation
- Early Retirement – payable at age 55 and 10 years of credited service.
- Disability Retirement – payable at any age with Social Security Disability, and 5 years of credited service including 5 years in the last 10.

NORMAL RETIREMENT BENEFITS

Effective 4/1/21, a lifetime monthly benefit payable for life starting at normal retirement age equal to $115.00 per month for each year of credited service for active journeymen and small works employees ($62.16 per month for active teledata employees, $37.29 per month for active sign employees, BA maintenance and fixture maintenance employees).

EARLY RETIREMENT BENEFITS

Same as Normal Retirement amount reduced by 1/6% for each month that you retire prior to age 65. For example, at age 60 your benefit would be reduced by 10%. At age 58 your benefit would be reduced by 14%. At age 55 your benefit would be reduced by 20%.

Plus, a monthly supplement of $1,900, payable between the ages of 55 and 62, provided you have been credited with at least 25 years of credited service (including 5 years in the last 10) as an inside or outside wireman; or $886 per month if you have 20 to 24 years of credited service (including 5 years in the last 10); or $634 per month if you have 10 to 19 years of credited service (including 5 years in the last 10).

DISABILITY RETIREMENT BENEFITS

Same as Normal Retirement amount with a minimum monthly benefit of $800 ($257.50 for sign employees and $140.00 for maintenance employees) with no reduction for early retirement and no supplemental benefit between the ages 55 and 62.

FORMS OF PAYMENT

Note: All forms are not available for disability retirement

- Life Annuity with 60 payments guaranteed
- Full Annuity with 120 payments guaranteed
- Full Annuity with 180 payments guaranteed
- Full Annuity with 240 payments guaranteed
- Spouse's Joint and 50% to Survivor with pop-up
- Spouse's Joint and 75% to Survivor with pop-up
- Spouses' Joint and 100% to Survivor with pop-up

PRE-RETIREMENT DEATH BENEFITS

Non-Vested Employee With 5 Years of Credited Service With at Least 3 Earned in Last 5 Years

- $2,500 times your years of credited service, max. $87,500, payable in a lump sum.

Vested Employee Under Age 55

- Lifetime benefit payable to your spouse, beginning when you would have reached age 55, equal to 50% of the amount you would have received had you retired at age 55 and elected the spouse's joint and 50% to survivor option, or
- $2,500 times your years of credited service, max. $87,500, payable in a lump sum.

Vested Employee Over Age 55

- Lifetime benefit payable to your spouse, equal to 50% of the amount you would have received had you retired and elected the spouse's joint and 50% to survivor option, or
- 60 monthly payments equal to the pension benefit you would have received had you retired.

POST RETIREMENT DEATH BENEFITS

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

IBEW LOCAL UNION 400 ANNUITY FUND

Effective October 1, 2019

YOUR ACCOUNT BALANCE IS EQUAL TO:

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

TYPES OF ANNUITY BENEFITS

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

- Disability Retirement– payable if totally and permanently disabled for at least 6 months.

- Partial Termination – 50% of your account balance payable if no covered employment over 15 consecutive days, but not more than two times in a calendar year.

- Full Termination –100% of your account balance payable if no covered employment over 24 consecutive months.

- Death - payable upon death.

- Participant Loans - available provided you have had an account balance for at least 3 years and is limited to 50% of your account balance or $50,000, whichever is less. Loans are available for the following purposes:

    - Medical expenses of at least $500 incurred by you, your spouse, or dependent child that have not been reimbursed by insurance.
    - Tuition and/or room and board expenses for you, your spouse or dependent child to attend and 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 or spouse's parent.
    - Unpaid mortgage payments for a primary residence due to financial hardship.

- Expenses due to being disabled for at least 14 consecutive days (not to exceed the New Jersey State disability benefit amount).
- Home improvement to your primary residence of at least $5,000.
- Wedding expenses of at least $5,000.

FORMS OF PAYMENT

- Lump Sum (available for retirement, disability, partial termination, or full termination if no covered employment over period of 24 consecutive months or if account balance is less than $10,000)

- Fixed or variable life annuity

- Combination lump sum and fixed or variable life annuity

- Joint and survivor life annuity (50% or 100%) with or without 120 payments guaranteed

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 400 ANNUITY FUND INVESTMENT CHOICES

Stable Value Fund

- Current Interest Rate Account

Specialty

- Nuveen Global Infrastructure

Small Cap Funds

- PGIM Quant Solutions Small Cap Index Fund
- Vanguard Explorer

Mid Cap Funds

- BlackRock Mid-Cap Growth Equity
- PGIM Quant Solutions Mid Cap Index Fund
- Vanguard Mid-Cap Value Index Fund

Large Cap Funds

- AQR Large Cap Defensive Style
- Federated Hermes Strategic Value
- PGIM Jennison Growth
- PGIM Quant Solutions Large – Cap Index Fund
- Vanguard Growth Index Fund
- Vanguard Value Index Fund

International Funds

- Invesco EQV International Equity
- Vanguard Developed Markets Index Fund
- Vanguard International Growth

Bond Fund

- Franklin US Government Securities

Balanced Fund

- PGIM Balanced

Asset Allocation

- JPMorgan SmartRetirement: Income, 2020, 2025, 2030, 2035, 2040, 2045, 2050, 2055, 2060 and 2065

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