IBEW LOCAL UNION 456
WELFARE, PENSION & ANNUITY FUNDS

QUICK REFERENCE GUIDE

EFFECTIVE: AUGUST 1, 2024

Important Notice: This is an outline of the principal plan provisions of the I.B.E.W. Local Union 456 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 UNION 456 WELFARE FUND

Effective June 1, 2018

ELIGIBILITY RULES – ACTIVE EMPLOYEES

You will become initially eligible on the first day of the second month following an employment period of not more than twelve consecutive months during which you have been credited with at least 1,200 hours of service.

If You Have 1,200 Hours During the Prior:	You Will Become Eligible:	And Will Remain Eligible Until At Least:
November Through October	December 1	May 31
December Through November	January 1	May 31
January through December	February 1	May 31
February through January	March 1	August 31
March through February	April 1	August 31
April through March	May 1	August 31
May through April	June 1	November 30
June through May	July 1	November 30
July through June	August 1	November 30
August through July	September 1	February 28 (29)
September through August	October 1	February 28 (29)
October through September	November 1	February 28 (29)

Apprentices, and, under certain conditions, employees of newly organized employers, will become initially eligible on the first day of the month following the completion of 300 hours of service within a period of six consecutive months.

If You Have 300 Hours During the Prior:	You Will Become Eligible:	And Will Remain Eligible Until At Least:
May through October	December 1	May 31
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)

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

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

Hours of service in excess of the hours required to establish and maintain eligibility will be placed in a reserve and will accumulate up to a maximum of 900 hours. These reserve hours 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. However, you are not entitled to receive reserve hours until you have been eligible to receive benefits for at least 24 consecutive months.

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.

Should your eligibility terminate, it will be reinstated provided you are credited with at least 300 hours of service during a calendar quarter which ends within 10 months from the date your eligibility terminated. Hours of service worked during the calendar quarter immediately preceding your termination date, plus any accumulated reserve hours, will be applied towards this 300 hour requirement.

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

If you do not satisfy this reinstatement provision, you will be treated as a new employee and will be subject to the 1,200 hour requirement for initial eligibility outlined above.

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 that follows the month for which your employer last makes required contributions.

COBRA

If you or your dependent loses eligibility, self-pay continuation of coverage is available under COBRA for up to 36 months. Your accumulated reserve hours will be applied before self-pay is required. The current monthly self-pay rates for the full plan under COBRA are:

Single	$ 658.00
Parent/Child(ren)	$ 987.00
Family	$1,316.00

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, or if disabled, you are eligible as an active employee in the Welfare Fund at the time of your retirement and you have earned a minimum of 20 years of Credited Service in the IBEW Local Union 456 Pension Fund, with at least 5 years of Credited Service in 10 years prior retiring.
- You have attained age 55 or are totally and permanently disabled.
- You are entitled to receive a monthly retirement benefit from the IBEW Local Union 456 Pension Fund (not required for non-bargaining employees).

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.

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 456 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 (not on COBRA) at the time of death:

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

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

Surviving spouse of active participants may continue coverage for an indefinite period of time at the current COBRA rates. Dependent children will continue to be covered at no additional cost until they meet the maximum age under the Plan. 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 1 year of guaranteed coverage, the dependent children would be able to continue the coverage for up to 36 additional months under COBRA.

Spouse and dependent children of a participant who was either retired or eligible for RETIREE 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 date your surviving spouse remarries.
2. The date your surviving spouse becomes eligible for health benefits under another group plan.
3. The date your dependent children cease to meet the definition of eligible dependent under the Plan (i.e. attaining the maximum age).

Surviving spouses of participants are covered at no cost for an indefinite period of time. Dependent children will continue to be covered at no additional cost until they meet the maximum age under the Plan. 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 1 year of guaranteed coverage, the dependent children would be able to continue the coverage for up to 36 additional months under COBRA.

IBEW LOCAL UNION 456 WELFARE FUND

TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **LIFE INSURANCE** - Active employees only – $30,000

- **DEATH BENEFIT** - Retired employees only - $10,000

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

- **TEMPORARY DISABILITY BENEFITS** - Active employees only
  - Weekly Benefit - $150
  - Waiting Period – 3 days; none if hospital confined
  - Maximum Benefit Period – 26 weeks

- **MEDICAL – AETNA**
  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 1-833-599-0940 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

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

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

- **HEALTH REIMBURSEMENT ARRANGEMENT (HRA)**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for more information

- **BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS - AETNA BEHAVIORAL HEALTH**
  Actives and Non-Medicare Eligible Retirees
  - o See following pages for plan information
  - o Call Aetna Behavioral Health at 1-800-424-4047, option 4 - 24/7 for urgent clinical matters
  - o 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 456 WELFARE FUND

BENEFITS
FOR

Active Employees
&
Non-Medicare
Eligible Retirees

IBEW LOCAL UNION 456 WELFARE FUND

SCHEDULE OF BENEFITS

Active Employees and Non-Medicare Eligible Retirees

AETNA CHOICE POS II NETWORK

EFFECTIVE DATE: JANUARY 1, 2023

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	$3,600	not applicable
Family	$7,200	not applicable
CO-INSURANCE	100%	not covered
LIFETIME MAXIMUM	unlimited	not applicable
DOCTOR'S OFFICE VISITS		
Primary Care Office Visit	100% after $10 co-pay	not covered
Specialist Office Visit	100% after $10 co-pay	not covered
Maternity Visits	100% after $10 co-pay (applies to 1st visit only)	not covered
Urgent Care	100% after $10 co-pay	not covered
PREVENTATIVE CARE (as defined by the Patient Protection and Affordable Care Act)		
	100% coverage	not covered
RWJ University Hospital Annual Physical Exam Program*		
	100% coverage (including $700 convenience fee)	not applicable

*This program includes health history, physical exam, vision and hearing screening, lab work, electrocardiogram, chest x-ray, exercise stress test, and consultation with exercise physiologist for nutrition and exercise evaluation. Eligibility for this program is limited to non-Medicare eligible active and retired participants and their dependents who are over age 21. For further information, please contact RWJ University Hospital at 732-253-3690.

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC PROCEDURES*		
Laboratory	100% coverage	not covered
Radiology	100% coverage	not covered
	*$10 co-pay if performed in doctor's office.	
HOSPITAL CARE		
Inpatient Admission	100% coverage	not covered
Inpatient Physician Services	100% coverage	not covered
Surgery in Hospital	100% coverage	not covered
Outpatient Hospital Services	100% coverage	not covered
*Inpatient hospital care requires prior authorization		
EMERGENCY CARE		
Emergency Room	100% after $50 copay	100% after $50 copay
*This copay is waived if admitted		
Ambulance	100% coverage	100% coverage
*Covers transport if emergent and medically necessary		
OUTPATIENT SURGERY		
Hospital Outpatient Surgery	100% coverage	not covered
Surgery in Ambulatory SurgiCenter	100% coverage	not covered
BEHAVIORAL HEALTH		
Office Visit	100% after $10 co-pay	not covered
Inpatient	100% coverage	not covered

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

	IN-NETWORK	OUT-OF-NETWORK
SUBSTANCE USE DISORDER		
Office Visit	100% after $10 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 $10 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.		
Skilled Nursing Care		
Inpatient	100% coverage	not covered
Outpatient	100% after $10 co-pay	not covered
*Maximum 120 days per calendar year. Medical treatment only.		
THERAPY SERVICES		
Occupational Therapy	100% after $10 co-pay	not covered
Physical Therapy	100% after $10 co-pay	not covered
Respiratory Therapy	100% after $10 co-pay	not covered
Speech Therapy	100% after $10 co-pay	not covered
*50 visits per person per calendar year		
All Other Covered Medical Services	100% coverage	not covered

Prior Authorization Requirements

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

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

In-Network Only

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

How to Find an AETNA Healthcare Provider

- Ask your physician, hospital, lab or other provider
- Go to Aetna's website at **www.aetna.com/docfind**
- Call I.E. Shaffer & Co. at 1-800-792-3666

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

Emergency services

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

Federal Law

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

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

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

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

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

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

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

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

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

IBEW LOCAL UNION 456 WELFARE FUND

PRESCRIPTION DRUG BENEFIT

Active Employees & Non-Medicare Eligible Retirees

Please call CAPITAL RX at 1-(833)-599-0940 for more information

Participating Retail Pharmacy

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

- Generic Drugs – $5 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $100 maximum
- Non-Preferred Brand Name Drugs – 20% co-payment, no maximum

Limitation: Up to 30-day supply (for 90-day supply – see below)

After $3,000 per person or $6,000 per family of out of pocket prescription expenses during a calendar year, there will be no co-payments required for the remainder of the year.

Mail Order and/or 90-Day Supply at Participating Retail Pharmacy

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

- Generic Drugs – $10 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $200 maximum
- Non-Preferred Brand Name Drugs – 20% co-payment, no maximum

Limitation: 90-day supply

After $3,000 per person or $6,000 per family of out of pocket prescription expenses during a calendar year, there will be no co-payments required for the remainder of the year.

Specialty Medication

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

There is an annual co-payment limit of $2,000 per person 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:

- Annual Deductible – none
- Coinsurance – 80%
- Annual Dental Maximum Benefit - $3,000/person
- Lifetime Orthodontic Maximum Benefit - $4,000/person

OR

Optional Dental Services Organization (DSO) Plan may be selected annually in lieu of the standard dental plan benefit. Under the DSO dental plan, all treatment will be provided at Eastern Dental offices located in New Jersey.

Features of the optional DSO dental plan include:

- No annual benefit maximum
- 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 and Non-Medicare Eligible Retirees or Non-Medicare Eligible Spouses of Retirees*

Exam and glasses/contacts 100% coverage

- Up to $500 per person towards eye exam and glasses/contacts combined
- Maximum benefit payable once every calendar year

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 $3,000 per person for age 15 and older
- Maximum benefit payable once every 36 months

IBEW LOCAL UNION 456 WELFARE FUND
Actives and Non-Medicare Eligible Retirees
BENEFIT PLAN MAXIMUMS

Annual Dental Maximum - $3,000 per person

Annual DSO Dental Plan Maximum – unlimited

Annual In-Network Medical Maximum Out-of-Pocket Limit-$3,600 person/$7,200 family
(Co-pays, deductibles and co-insurance count towards this out-of-pocket limit)

Annual Prescription Maximum Out-of-Pocket Limit - $3,000 person/$6,000 family
(Prescription co-pays count towards this limit)
For active employees and non-Medicare eligible retired employees only

Chiropractic Care Maximum – 30 visits per person per calendar year

Hearing Aids – Unlimited benefit up to age 15. Up to $3,000 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

Hospice Care Maximum – 120 visits per calendar year, 4 hours = 1 visit, excludes respite care, pastoral care and counseling

Infertility Treatment - $20,000 per person lifetime maximum plus an additional $40,000 per person lifetime maximum, subject to a 50% co-payment. Plan will cover artificial insemination and prescription fertility drugs as an unlimited benefit.

Lifetime Maximum for Surgical Procedures Performed to Correct Myopia (Near Sightedness) or Hyperopia (Far Sightedness) - $5,000/person

Lifetime Orthodontia Maximum - $4,000/person

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

Speech Therapy Maximum – 50 visits per person per calendar year, up to $50 per visit

IBEW LOCAL 456 SUPPLEMENTAL WELFARE FUND

BENEFITS
FOR

MEDICARE ELIGIBLE RETIREES

IBEW LOCAL UNION 456 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 Unlimited visits (In lieu of anesthesia and for treatment of chronic pain)
Podiatry	$0 Unlimited visits
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 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 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 456 SUPPLEMENTAL WELFARE FUND
PRESCRIPTION DRUG BENEFIT
Medicare Eligible Retirees & Medicare Eligible Spouses of Retirees

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

Participating Retail Pharmacy

Group Medicare Part D Plan from RetireeFirst

Maximum **30-day** supply:

- Generic Drugs - $5 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $100 maximum
- Non-Preferred Brand Name Drugs – 20% co-payment, no maximum

Mail Order and/or 90-Day Supply at Participating Retail Pharmacy

Group Medicare Part D Plan from RetireeFirst

Maximum **90-day** supply:

- Generic Drugs - $10 co-payment
- Preferred Brand Name Drugs – 20% co-payment, $200 maximum
- Non-Preferred Brand Name Drugs – 20% co-payment, no maximum

Specialty Drugs

- 20% co-payment, $200 maximum (30-day supply maximum)

DENTAL BENEFIT

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

- Annual Deductible – none
- Coinsurance – 80%
- Annual Dental Maximum Benefit - $3,000/person
- Lifetime Orthodontic Maximum Benefit - $4,000/person

OR

Optional Dental Services Organization (DSO) Plan may be selected annually in lieu of the standard dental plan benefit. Under the DSO dental plan, all treatment will be provided at Eastern Dental offices located in New Jersey.

Features of the optional DSO dental plan include:

- No annual benefit maximum
- 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 456 WELFARE FUND
HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The IBEW Local 456 Welfare Fund has a Health Reimbursement Arrangement (HRA). The HRA is available to all employees, non-bargaining employees and employers who are eligible for benefits from the Welfare Fund.

- Each eligible employee's HRA account is funded by contributions equal to 1% of pay for all hours worked after the latter of January 1, 2015 or the employee's initial eligibility date in the Welfare Fund.

- Employers and non-bargaining employees have an HRA account that is funded with an amount equal to 1% of the applicable Journeyman's pay rate at 150 hours per month.

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.

IBEW LOCAL UNION 456 PENSION FUND

Effective August 14, 2023

IMPORTANT TERMS

- Plan Year - Jan 1st to Dec 31st
- Credited Service
    - For service after 1/1/2000, ½ year of credit for each 500 hours of service up to a maximum of 1 year of credit for 1,000 hours.
    - For service prior to 1/1/2000, credit is based upon prior plans 456 and 358.
- Supplemental Credited Service
    - For service after 1/1/2000 – none.
    - For service prior to 1/1/2000, credit is based upon prior plans 456 and 358.
- Vested Service - 1 year of credit for 1,000 hours of service (no partial credit).
- 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 any credited service.

TYPES OF PENSION BENEFITS

- Normal Retirement – payable at age 62 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 10 years of credited service.

NORMAL RETIREMENT BENEFITS

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

- $1.00 per month for each full $100.00 of contributions after 1/1/2003, plus,
- $1.00 per month for each full $60.00 of contributions from 1/1/2000 to 12/31/2002, plus,
- $1.15 per month for each full $50.00 of contributions from 10/1/1989 to 12/31/1999 earned under prior plan 456, plus,
- $58 per month for each year of credited service and supplemental credited service earned prior to 10/1/1989 under prior plan 456, plus
- $60 per month for each year of credited service earned under prior plan 358.

EARLY RETIREMENT "DOUBLE" BENEFITS (RETIREMENTS ON OR BEFORE DECEMBER 1, 2023)

Same as Normal Retirement amount reduced by 1/3% for each month that you retire prior to age 62. For example, at age 60 your benefit would be reduced by 8%. At age 58 your benefit would be reduced by 16%. At age 55 your benefit would be reduced by 28%. Plus, a "double" supplement payable between the ages of 60 and 62 equal to your early retirement benefit determined above provided you have been credited with at least 5 years of credit service during 5 consecutive plan years ending on or after age 50.

ENHANCED EARLY RETIREMENT "DOUBLE" BENEFITS (RETIREMENTS ON OR AFTER JANUARY 1, 2024)

Same as Normal Retirement amount reduced by 1/3% for each month that you retire prior to age 62. For example, at age 60 your benefit would be reduced by 8%. At age 58 your benefit would be reduced by 16%. At age 55 your benefit would be reduced by 28%. Plus, a total of 24 monthly "double" supplemental payments equal to your early retirement benefit determined above provided you have been credited with at least 5 years of credit service during 5 consecutive plan years ending on or after age 50, AND are credited with 1 years of Credited Service in each Plan year between age 60 and the last full Plan year prior to the effective date of your early retirement.

NEW NORMAL RETIREMENT 24 MONTH "DOUBLE" SUPPLEMENTAL BENEFITS (RETIREMENTS ON OR AFTER JANUARY 1, 2024)

You will receive a total of 24 monthly "double" supplemental payments equal to your normal retirement benefit provided you have been credited with at least 5 years of credit service during 5 consecutive plan years ending on or after age 50, AND are credited with 1 year of Credited Service in each Plan year between age 60 and the last full Plan year prior to the effective date of your normal retirement.

DISABILITY RETIREMENT BENEFITS

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

FORMS OF PAYMENT (applicable reduction)

Note: All forms are not available for disability retirement

- Life Annuity with 120 payments guaranteed – (no reduction) - available for disability
- Life Annuity with 180 payments guaranteed (7% reduction at age 62; 3.5% at age 55)
- Life Annuity with 240 payments guaranteed (13% reduction at age 62; 8.1% at age 55)
- Spouse's Joint and 50% to Survivor (5% reduction if spouse's age is within 5 years) - available for disability with 10% reduction
- Spouse's Joint and 75% to Survivor (8% reduction if spouse's is same age) - available for disability with 13% reduction
- Spouses' Joint and 100% to Survivor (10% reduction if spouse is same age)
- Lump sum - value based on your monthly benefit, your age, and current interest rates for benefits accrued prior to 1/1/06. Payable after 24 consecutive months of retirement – monthly benefit may be paid during waiting period. Please note, that if you elect a lump sum, you are not eligible for the supplemental "double" benefit.

PRE-RETIREMENT DEATH BENEFITS

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

- $4,000 times your years of credited service, 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 the full amount you would have received had you retired at age 55 and elected the spouse's joint and 50% to survivor option, or
- $4,000 times your years of credited service, payable in a lump sum, provided you have either 3 years of credited service earned in the last 5 years, or more than 20 years of credited service.

Vested Employee Over Age 55

- Lifetime benefit payable to your spouse, equal to the full amount you would have received had you retired and elected the spouse's joint and 50% to survivor option, or $4,000 times your years of credited service, payable in a lump sum, provided you have either 3 years of credited service earned in the last 5 years, or more than 20 years of credited service.
- If unmarried, the greater in the aggregate of 120 monthly payments equal to the pension benefit you would have received had you retired, or $4,000 times your years of credited service, payable in a lump sum, provided you have either 3 years of credited service earned in the last 5 years, or more than 20 years of credited service.

Totally Disabled Employee With At Least 10 Years of Service

- 120 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 456 ANNUITY FUND

Effective February 1, 2023

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 – payable if totally and permanently disabled.

- Termination – payable if no covered employment over 3 consecutive months.

- Death - payable upon death.

- Financial Hardship - If you have been a participant under the Plan for at least 3 years, you may apply for a financial hardship distribution. All hardship distributions will be limited to the amount of money actually required for the purpose indicated below, but not more than the value of your account. No more than three (3) financial hardship distributions are permitted during a 12 month period except that those for educational purposes or unemployment will not apply to this limitation.

    - Medical expenses of at least $500 incurred by you or your spouse, dependent child, parent or grandchild that have not be reimbursed by insurance.
    - Tuition 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.
    - Home Improvement
    - To prevent foreclosure or eviction from your principal residence.
    - Funeral expenses incurred due to the death of your spouse, child or parent.

- Unemployment or temporary disability – a matching benefit equal to the benefit paid to you under the New Jersey State Unemployment Fund or the Temporary Disability Benefit Fund.
- Legal fees and expenses of at least $1,000 incurred by you, your spouse, or dependent children in the defense or prosecution of civil or criminal litigation.
- Delinquent back income or real estate property taxes due by you or your spouse.
- Educational Loans – available to participants who have at least 3 years of participation not to exceed 50% of account balance or $50,000, whichever is less. The interest rate charged on a loan is equal to the prime rate plus ½%. Loans are available for educational expenses for yourself, your spouse, dependent child or a grandchild who is enrolled as a full time or part time student at an accredited elementary, secondary, college, university or school for the physically or mentally handicapped.

FORMS OF PAYMENT

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

FEDERAL AND STATE INCOME TAXES

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

INVESTMENT CHOICES:

Large Value

- Vanguard Equity Fund

Large Blend

- American Funds Washington Mutual Fund
- Vanguard Institutional Index Fund

Large Growth

- American Funds Growth Fund of America

Mid-Cap Blend

- Columbia Mid Cap Index Fund

Small Blend

- Delaware Small Cap Core Fund

Real Estate

- Cohen & Steers Real Estate Securities Fund

Commodities Broad Basket

- PIMCO Commodity Real Return Strategy Fund

Foreign Large Blend

- MFS International Diversification Fund

Short Government

- Vanguard Short-term Federal Fund

Intermediate Core-Plus Bond

- PGIM Total Return Bond Z Fund

Stable Value

- Prudential Stable Value Fund

Target Date

- T. Rowe Price Retirement Balanced Fund - 2010, 2020, 2030, 2040 and 2050 Funds – default choices based on age

Investment earnings credited daily. Investment elections may be changed daily. Access your Empower account with your PIN 24 hours a day, 7 days a week – (1-(877)-778-2100)