IBEW LOCAL UNION 94
HEALTH & WELFARE FUND and ANNUITY FUND

QUICK REFERENCE GUIDE

EFFECTIVE: JANUARY 1, 2025

Important Notice: This is an outline of the principal plan provisions of the I.B.E.W. Local Union 94 Health & Welfare Plan 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. Annuity Fund Participants should call NWPS at 888-700-0808 for Plan information and account detail.

IBEW LOCAL UNION 94 HEALTH & WELFARE FUND

Effective January 1, 2023

ELIGIBILITY RULES

Initial Eligibility

You will become eligible for benefits on the first day of the second month following a period of three consecutive months during which you work a minimum of 420 hours. Upon satisfying this requirement, you will remain eligible for at least three months.

If You Earn 420 Hours of Service During the Prior:	You Will Become Eligible:
September through November	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

Continuing Eligibility and Termination

To remain eligible, you must have at least 420 hours of service each calendar quarter period. Your eligibility will terminate on the last day of the second month following the calendar quarter period during which you fail to receive credit for at least 420 hours.

If You Have Less Than 420 Hours of Service Per Calendar Quarter Period:	Your Eligibility Will Terminate On:
January through March	May 31
April through June	August 31
July through September	November 30
October through December	February 28 (29)

Reserve (Banked) Hours

Hours of service in excess of 420 hours during the calendar quarter will be placed in a reserve (bank) and will accumulate up to a maximum of 420 hours for employees who have established initial

eligibility. This reserve will be drawn upon to maintain your eligibility if you should fail to receive credit for at least 420 hours of service during a calendar quarter period, and provided you are available for work under a Local 94 Collective Bargaining Agreement requiring contributions to this Fund. Reserve hours may be used to provide coverage to the full contract (employee and dependents(s) (spouse, child/ren, family)) for that quarter in which the shortage occurred and during which the participant had employer hours reported.

Reserve Hours may not be used if you have zero hours reported by the employer during the calendar quarter period. If no contributions by any employer included in the Local 94 Collective Bargaining Agreement are received within 12 months following your last month worked, you will lose any remaining Reserve Hour balance and such reserve hours shall terminate from your record indefinitely.

In the event a participant: leaves covered employment and has Welfare coverage elsewhere, voluntarily leaves covered employment to take a management position, does a cessation or has other hospital/medical coverage available through a reciprocal agreement, such employee is not permitted to use any banked hours, and all banked hours shall be forfeited.

Self-Pay Provision

If a participant does not have 420 hours worked during the calendar quarter period and his employment has been terminated, the participant has the option to self-pay the amount of contributions required to maintain eligibility for a maximum of one calendar quarter period. Coverage will be for the participant and eligible dependents, if applicable. If during the next consecutive calendar quarter period the participant does not have 420 credit hours to maintain eligibility, coverage (including any dependent coverage) will terminate. Self-pay is to be permitted if a participant transfers to another company within the Plan but failed to reach the 420 hours requirement for that quarter.

The Fund will notify the participant in writing, by regular mail sent to the address on file, of the amount of the short fall in contributions. The participant will be given thirty (30) calendar days from the date of notice within which to make payment of the shortfall in order to maintain continuing eligibility without a break. Payment must be received at the Fund Office no later 4:00 p.m. of the last day of the (30) day calendar period. If the "last day" is a Saturday, Sunday or federal legal holiday, the last day shall be extended to the next regular business day.

Disability

If you become disabled and you are terminated, you will be credited hours for a three month period from the date of your termination. On the fourth month from the date of your termination due to disability, you must self-pay to continue benefits (COBRA).

Reinstatement

Should your eligibility terminate, you will be treated as a new employee and will be subject to the requirement for initial eligibility outlined above.

Dependent Eligibility

Your eligible Dependents are defined as:

- Your Spouse, which is the person to whom you are legally married, as determined by applicable state law, until the marriage is ended by divorce or legal separation or other judicial separation. (certified copy of your marriage certificate is required)
- Your Domestic Partner per The Domestic Partnership Act effective July 10, 2004 and amended by the Civil Union Act implemented on February 19, 2007. (certified copy of the certificate of your Registered Domestic Partnership is required)
- Your Dependent Child/Children until the last day of the calendar year in which the child reaches age 26.

  Dependent Child/Children covered up to age 26 include:

  a) Your natural children (birth certificate is required);
  b) Legally adopted children and children placed with you for adoption (proof of adoption or placement for adoption are required)
  c) Stepchildren (birth certificate and/or proof of adoption or placement for adoption as well as your marriage certificate are required).

- A child that the Plan is required to cover for benefits under a Qualified Medical Child Support Order (QMCSO). Notify the Trust Fund Office if you become aware of an order like this. Such an order could have an effect on your benefit coverage or elections. A free copy of the Plan's QMCSO procedures is available from the Trust Fund Office.

Coverage will continue for a Child Dependent beyond the age of 26 if, immediately prior to reaching that age, he/she was enrolled under this Plan and is incapable of self-sustaining employment by reason of intellectual disability or physical handicap. For your handicapped Child Dependent to remain covered, you must submit proof of his/her inability to engage in self-sustaining employment by reason of intellectual disability or physical handicap within 31 days of the child's attainment of age 26. The proof must be in a form that meets medical approval.

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. **If you do not notify the Fund Office nor mail back the Enrollment/Change Request Form within 60 days, you will and/or your dependents will be considered to have waived your right to COBRA continuation coverage.**

The current options and monthly self-pay rates under COBRA are:

OPTION 1A: MEDICAL, RX, VISION, HORIZON DENTAL

Single	$647.41
2 Adult	$1974.57
Family	$2677.70
Parent/Child	$1542.04

OPTION 2: MEDICAL, RX, VISION, NO DENTAL

Single	$631.42
2 Adult	$1939.63
Family	$2623.86
Parent/Child	$1507.10

OPTION 3A: HORIZON DENTAL ONLY

Single	$15.99
2 Adult	$34.94
Family	$53.85
Parent/Child	$34.94

Please note that these rates are subject to review by the Board of Trustees and may be adjusted periodically.

IBEW LOCAL UNION 94 HEALTH & WELFARE FUND
BENEFIT PLANS OFFERED BY THE HEALTH & WELFARE FUND

Please be sure to use the correct ID for the service you are receiving.

Your Medical ID card is Medical services only with your ID# F3N on your ID card.
For most prescriptions at the pharmacy, you must use your pharmacy ID card with the 3HZN#.

- **MEDICAL – Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for member services

- **PRESCRIPTION – Prime Therapeutics/Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call Prime Therapeutics at 1-800-370-5088 for more information

- **BEHAVIORAL HEALTH – Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for member services

- **DENTAL– Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call Horizon at 1-800-433-6825

- **VISION – Horizon Vista II (Horizon/Davis Vision View Network)**
  - See following pages for information
  - Call Horizon (Davis) Vision at 1-800-278-7753 for more information

- **TERM LIFE/ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) – USAble Life**
  - Active and eligible employees: $25,000 active eligible employees
  - Retired employees with 20 years of continuous service: $25,000 and benefits reduce to 50% at age 70
  - Call I.E. Shaffer & Co. at 1-800-792-3666

IBEW LOCAL UNION 94 HEALTH & WELFARE FUND

SCHEDULE OF BENEFITS

HORIZON BLUE CROSS BLUE SHIELD DIRECT ACCESS with BlueCard
EFFECTIVE DATE: JANUARY 1, 2022

MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE		
(Calendar Year)		
Individual	$0	$300
Family	$0	$600
ANNUAL OUT-OF-POCKET MAXIMUM		
(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. In-Network and Out-of-Network limits are combined.		
Medical		
Individual	$4,500	$4,500
Family	$9,000	$9,000
Prescription		
Individual	$500	
Family	$1,000	
CO-INSURANCE	100%	80%
LIFETIME MAXIMUM	unlimited	unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Office Visit	100% coverage after $20 co-pay	80% coverage after deductible
Specialist Office Visit	100% coverage after $20 co-pay	80% coverage after deductible
Maternity Visits	100% coverage after $20 co-pay (copay applies to 1st visit only)	80% coverage after deductible
Urgent Care Center	100% coverage after $20 co-pay	80% coverage after deductible

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE (as defined by the Patient Protection and Affordable Care Act)		
	100% coverage No deductible and no co-pay apply	80% coverage No deductible and no co-pay apply
DIAGNOSTIC PROCEDURES		
Laboratory	100% coverage	80% coverage after deductible
Radiology	100% coverage	80% coverage after deductible
HOSPITAL CARE		
Inpatient Admission *Inpatient Hospital Care requires prior authorization	100% coverage	80% coverage after Deductible
Inpatient Physician Services	100% coverage	80% coverage after deductible
Surgery in Hospital - Inpatient	100% coverage	80% coverage after deductible
EMERGENCY CARE		
Emergency Room -facility	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)
Emergency Room – professional fee	100% coverage	100% coverage
Ambulance *Covers transport if emergent and medically necessary	100% coverage	80% coverage after deductible

	IN-NETWORK	OUT-OF-NETWORK
SURGERY		
Hospital Outpatient Surgery	100% coverage	80% coverage after deductible
Surgery in Ambulatory SurgiCenter	100% coverage	80% coverage after Deductible
Surgery in Doctor's Office	100% after $20 copay	80% coverage after deductible
BEHAVIORAL HEALTH		
Office Visit	100% coverage after $20 co-pay	80% coverage after deductible
Inpatient	100% coverage	80% coverage after deductible
**Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization*		
SUBSTANCE USE DISORDER		
Office Visit	100% coverage after $20 co-pay	80% coverage after deductible
Inpatient	100% coverage	80% coverage after deductible
**Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization*		
OTHER SERVICES		
Chiropractic Care Visit *Up to 25 visits per person per calendar year	100% coverage after $20 co-pay	80% coverage after deductible
Home Health Care Services *Out of Network Maximum 100 visits per calendar year, 4 hours=1 visit, no custodial care. Prior authorization required.	100% coverage	80% coverage after deductible
Hospice Services *Maximum 10 respite days. Excludes pastoral care and counseling.	100% coverage	80% coverage after deductible
Skilled Nursing Facility	100% coverage	80% coverage after deductible
*In-Network – 100 day limit per calendar year / Out-of-Network – 60 day limit per calendar year		

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing	100% coverage	80% coverage after deductible

*240 hours combined INN and OON per calendar year

THERAPY SERVICES

Occupational Therapy (30 visit maximum per calendar year)		
Out-patient facility	100% coverage after $20 co-pay	80% coverage after deductible
Provider's office	100% coverage after $20 co-pay	80% coverage after deductible
Physical Therapy (30 visit maximum per calendar year)		
Out-patient facility	100% coverage after $20 co-pay	80% coverage after deductible
Provider's office	100% coverage after $20 co-pay	80% coverage after deductible
Speech Therapy (30 visit maximum per calendar year)		
Out-patient facility	100% coverage after $20 co-pay	80% coverage after deductible
Provider's office	100% coverage after $20 co-pay	80% coverage after deductible
Respiratory Therapy (30 visit maximum per calendar year)		
Out-patient facility	100% coverage after $20 co-pay	80% coverage after deductible
Provider's office	100% coverage after $20 co-pay	80% coverage after deductible
WIGS	100% coverage	100% coverage

*$500 every 24 months with diagnosis of alopecia or hair loss due to radiation or chemotherapy

PRIOR AUTHORIZATION REQUIREMENTS:

Benefits may be denied if prior authorization is not obtained for the below services:

For all **in-patient hospital** stays, providers must receive prior authorization from or Horizon Blue Cross Blue Shield **at least 24 hours prior to admission**.
Emergency admissions must be authorized within 72 hours after hospital admission.

Radiology:

- Stress Testing: Myocardial Perfusion Imaging (SPECT and PET), Stress Echocardiography
- Echocardiography: transthoracic and transesophageal
- Diagnostic Heart Catherization
- Implantable Device Services: Pacemakers, Implantable cardioverter Defibrillator (ICD)
- Advanced Imaging: Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiograms (MRAs), Positron Emission Tomography (PET) scans, Positron Emission Tomography – computed tomography (PET-CT), Computed Tomography Angiography (CTA) scans, Nuclear Medicine and Nuclear Cardiac Imaging

Pain Management:

- Epidural Injections
- Facet Joint Injections
- Medial Branch Blocks
- Interventional Pain Procedure Imaging
- Monitored Anesthesia for Interventional Pain Procedures

Spine Surgery:

- Decompressions and Fusions
- Vertebroplasty/Kyphoplasty
- Discectomy
- Disc Arthroplasty

Radiation Therapy:

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

- Radiopharmaceuticals

Specialty Pharmaceuticals

Medical Infertility Services*
**Providers must contact I.E. Shaffer @ 800-792-3666 for prior authorization*

PROVIDER PHONE RESOURCES: HORIZON MEDICAL/BEHAVIORAL HEALTH
Behavioral Health Services: 1-800-626-2212
Utilization Management: 1-800-664-2583
Provider Services: 1-888-456-7910
Advanced Radiology Prior Auth: 1-866-496-6200
Spine/Pain Management Services: 1-855-339-2010

How to Find a Horizon Blue Cross Blue Shield of New Jersey 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

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 no cost to members 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 <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 94 HEALTH & WELFARE FUND

PRESCRIPTION DRUG BENEFIT

PRIME THERAPEUTICS/HORIZON BLUE CROSS BLUE SHIELD NJ

Retail Prescriptions*

Retail co-pay per Days of Supply: 1 to 30-day supply = 1 co-pay
31 to 60-day supply = 2 co-pays
61 to 90-day supply = 3 co-pays

- Generic Drugs – $10 co-payment
- Preferred Brand Name Drugs – $25 co-payment
- Non-Preferred Brand Name Drugs – $50 co-payment

Mail Order and/or 90 Day Supply Retail Prescriptions*

Mail Order co-pay per Days of Supply: 90-day supply = 2 co-pays

- Generic Drugs – $20 co-payment
- Preferred Brand Name Drugs – $50
- Non-Preferred Brand Name Drugs – $100

*After $500 per person or $1,000 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. 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.

HORIZON DENTAL BENEFITS:

* Annual Deductible applies + Annual Maximum applies		**Dental Option Plan**
Annual Deductible		$50 per person, 3 per family
Out-of-network		Yes
Annual Maximum (Includes Dental & Orthodontics for children to age 19)		$1,500 per family
COVERED SERVICES		**OUT-OF-POCKET COSTS**
Exams and PreventiveServices +	Eligible exams, 3 per yearFluoride treatment (child), Sealant application Prophylaxis	0%
X-rays+	Panoramic Full-mouth X-rays	0%
Space maintainers*+	Space maintainers – fixed unilateral/bilateral	50%
Restorations and Repairs*+	Amalgam restorations Composite restorations(other than for molars) Denture adjustments and repairs	50%
Endodontics*+	Pulp cap/Pulpotomy Root canal therapy – anterior, bicuspid, molar	50%
Periodontics*+	Scaling and root planing Gingivectomy Soft tissue grafts Periodontal maintenance Osseous surgery	50%
Oral Surgery*+	Routine extractions Soft tissue surgical extractions Incision and drainage of abscessSurgical extractions-impacted	50%
COVERED SERVICES		**OUT-OF-POCKET COSTS**
Major Restoration*+	Crowns	50%
Dentures*+	Complete and partial dentures	50%
Fixed Bridges*+	Retainers and pontics	50%
Orthodontic Procedures*	Children to age 19 only. Limited to one complete orthodontic treatment per lifetime.	50%

HORIZON VISION BENEFITS:

		Horizon Vista II
		Once every:
Eye examination including dilation (when professionally indicated)	Spectacle lenses	12 months
Contact lens evaluation, fitting and follow-up care	Contact lenses (in lieu of eyeglasses)	
Frame		24 months
		Copayments
Eye examination		$10
Spectacle lenses		$25
Eyeglass Benefit — Frame		**Member charges**
Non-collection frame allowance (retail)		Up to $100 or $150[1] plus 20% discount[2] on any over overage
Davis Vision Frame Collection[3] (in lieu of allowance): Fashion level / Designer level / Premier level		Included / $15 / $40
Eyeglass Benefit — Spectacle Lenses		
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)		Included
Oversize lenses / Tinting of plastic lenses / Scratch-resistant coating		Included / $15 / Included
Polycarbonate lenses[4]/ Ultraviolet coating		$0 or $35 / $15
Anti-reflective (AR) coating (standard / premium / ultra / ultimate)		$40 / $55 / $69 / $85
Progressive lenses (standard / premium / ultra / ultimate)		$65 / $105 / $140 / $175
High-index lenses		$60
Intermediate-vision lenses		$30
Polarized lenses / Plastic photochromic lenses		$75 / $70
Scratch Protection Plan: Single vision / Multifocal lenses		$20 / $40
Blue Light Filtering		$15
Contact Lens Benefit (in lieu of eyeglasses):		
Contact lenses: Materials allowance		Up to $100 plus a 15% discount[2] on any overage
Evaluation, fitting and follow-up care — standard and specialty lens types		15% discount[2]
Medically required contact lenses (with prior approval) Materials, evaluation, fitting and follow-up care		Included
Out-of-Network Reimbursement Schedule up to:		
Eye examination		$40
Single Vision Lenses		$40
Bifocal		$60
Spectacle lenses Trifocal		$80
Lenticular		$100
Frame		$50
Elective Contacts		$80
Visually Required Contacts		$225

HEARING BENEFIT

Coverage for children 15 years old and younger only:

Benefit limited to one medically necessary hearing aid for each hearing-impaired ear every 24 months, no dollar limit.

This covers medically necessary hearing aids, including fittings, exams, hearing tests, dispensing fees, modification and repairs, ear molds and headbands for bone anchored hearing implants.

Audiologist Services (Provider/Facility):
In-network: 100% coverage
Out-of-network: 80% coverage after deductible

For other related services, benefits payable the same as for an office visit to a Primary Care Physician/Practitioner.

Excludes anyone age 16 and older.

IBEW LOCAL UNION 94 HEALTH & WELFARE FUND

WELFARE FUND BENEFIT PLAN MAXIMUMS

Annual In-Network/Out-of-Network Medical Maximum Out-of-Pocket Limit-$4,500 person/$9,000 family (Co-pays, deductibles and co-insurance count towards out-of-pocket limit)

Annual Prescription Maximum Out-of-Pocket Limit - $500 person/$1,000 family
(Prescription co-pays count towards this limit)

Home Health Care Maximum - In-Network =Unlimited visits per calendar year, Out-of-Network= 100 visits per calendar year, 4 hours = 1 visit, no custodial care

Hospice Care Maximum – 10-day limit for respite care, excludes pastoral care and counseling

Skilled Nursing Care Maximum – In-Network = 100 days per calendar year, Out-of-Network = 60 days per calendar year. Medical treatment only

Hearing Aids – Only covered for age 15 or younger

Occupational Therapy Maximum – 30 visits per calendar year

Physical Therapy – 30 visits per calendar year

Respiratory Therapy – 30 visits per calendar year

Speech Therapy Maximum – 30 visits per calendar year

Chiropractic Care Maximum – 25 visits per person per calendar year

Infertility Treatment – $20,000 per calendar year/$50,000 lifetime maximum on medical services. Limit of 4 completed egg retrievals. Coverage includes IVF, GIFT, ZIFT and IUI. Diagnostic testing and medications are not subject to the plan maximum. All benefit inquiries regarding infertility must directed to the fund office.

Annual Dental Maximum - $1,500 for dental and orthodontia services per family per calendar year

Orthodontia – Services only available up until age 19; one complete orthodontic treatment per lifetime per child.

Injury Involving a Motor Vehicle - Services or treatment for injuries resulting from a motor vehicle accident or involving a motor vehicle will only be paid by the Local 94 IBEW Welfare Fund on a secondary basis, whether or not coverage exists under Personal Injury Protection coverages, Medical Payment Benefits, or Basic Reparation Benefit coverages. This exclusion of primary coverage applies whether or not a proper and timely claim for payment for these services is made under the motor vehicle insurance policy. Please see SPD for full details

Local 94, IBEW | **Employee Benefits Summary**

USAble Life is proud to make the following insurance products available to Eligible Members of IBEW Local 94:

ACTIVE EMPLOYEES
GROUP TERM LIFE/ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) |
$25,000
These benefits terminate when you are no longer eligible for your retirement, whichever occurs first. Eligible employees may enroll in the retiree benefit (listed below) upon retirement.

RETIRED EMPLOYEES WITH 20 YEARS OF CONTINUOUS SERVICE

GROUP TERM LIFE | $25,000

Benefits reduce to 50% at your age 70 and may terminate should you become ineligible.

IMPORTANT NOTE: If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a policy or certificate of insurance. Please read your insurance documents carefully.

GROUP TERM LIFE insurance is designed to provide benefits to your designated beneficiary for loss of life.

Group Term Life coverage also includes the following benefits:
Accelerated Benefit
Extended Life Insurance Benefit (Waiver of Premium)

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job. AD&D benefits are only available to Active Employees of Local 94, IBEW.

AD&D coverage also includes the following benefits:
Seat Belt/Air Bag Rider Benefit
Coma Benefit
Exposure & Disappearance Benefit
Repatriation Benefit
Paralysis Rider
Special Education Rider

ADDITIONAL SERVICES

WITH GROUP TERM LIFE COVERAGE:

ASSIST AMERICA is a global emergency medical travel assistance company. Anytime you, your spouse and/or minor dependent children are traveling 100 miles or more away from home or in another country—with or without you present, they are protected by Assist America's vast assistance resources. A single phone call is all it takes to put Assist America in motion on your behalf.

ONLINE WILL PREP is a will preparation service. Living will documents are also available at no cost. Go to www.estateguidance.com to create a simple or living will and use Promotional Code USW.