PLUMBERS LOCAL 24
WELFARE & ANNUITY FUNDS

QUICK REFERENCE GUIDE

FOR RESIDENTIAL DIVISION

EFFECTIVE: JANUARY 1, 2025

Important Notice: This is an outline of the principal plan provisions of the Plumbers Local Union 24 Welfare 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.

PLUMBERS LOCAL 24 WELFARE FUND – RESIDENTIAL DIVISION

Effective July 1, 2024

TYPES OF COVERAGE

Upon the employee's initial employment, they must notify the employer of the type of Welfare Fund coverage they wish to have. Contact the Fund Office to request the enrollment forms which should then be completed and returned back to the Fund Office prior to working. The choices are either Single Coverage, Family Coverage (which includes Husband/Wife and Parent/Child) or you can decline coverage.

Participants who:

- decline coverage will receive an Annuity Fund contribution of $9.50 per hour
- elect Single coverage will receive an Annuity Fund contribution of $6.50 per hour
- elect Family Coverage will receive an Annuity Fund contribution of $3.50 per hour

ELIGIBILITY RULES – ACTIVE EMPLOYEES

You will become eligible to receive benefits on the first day of the second month that follows an employment period of not more than 6 consecutive months during which you have been credited with 80 hours of service. Upon satisfying this requirement, you will remain eligible for a minimum of three months:

If You Have 80 Hours During the Prior:	You Will Become Eligible:	And Will Remain Eligible Until At Least:
June through November	January 1	May 31
July through December	February 1	May 31
August through January	March 1	August 31
September through February	April 1	August 31
October through March	May 1	August 31
November through April	June 1	November 30
December through May	July 1	November 30
January through June	August 1	November 30
February through July	September 1	February 28 (29)
March through August	October 1	February 28 (29)
April through September	November 1	February 28 (29)
May through October	December 1	May 31

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 600 hours. This reserve will be drawn upon to maintain your eligibility if you should fail to receive credit for at least 300 hours of service during a subsequent calendar quarter.

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.

10 MONTH REINSTATEMENT PROVISION

Should your eligibility terminate, it will be reinstated provided you are credited with at least 300 hours of service within the 10 month period following your termination. 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. If you do not satisfy this reinstatement provision, you will be treated as a new employee and will be subject to the 80 hour requirement for initial eligibility outlined above.

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

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

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

COBRA

If you fail to meet the eligibility requirements and lose eligibility, self-pay continuation of coverage is available under COBRA for up to 18 months. If your dependent loses eligibility due to your death, divorce, or your child attaining the maximum eligible age, 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 present monthly COBRA rates are as follows:

Single	$ 552
Parent/Child(ren)	$ 828
Husband/Wife	$ 938
Family	$1,104

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 mental retardation 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.

HOW TO CHANGE THE TYPE OF COVERAGE YOU HAVE SELECTED

OPEN ENROLLMENT:
Participants will be notified by November 1st of each year regarding Open Enrollment during which they will be able to change their coverage selection for the upcoming year if they wish to do so.

SPECIAL ENROLLMENT PERIOD:
An employee must file a new enrollment card with the Fund Office within 30 days of marriage, the birth of a child or adoption of a child. The effective date of coverage as the result of such an event shall be:

- the date of the marriage
- the date of a dependent's birth
- the date of adoption

All of the above will require the submission of the required documents such as a marriage certificate, birth certificate or adoption certificate.

Participants or their dependents who did not initially enroll for coverage due to other coverage may request to be covered by this plan if they are no longer eligible for the other coverage. This option will be granted if the loss of eligibility is related to:

- Termination of the other coverage
- End of employer contributions towards the other coverage
- Legal separation or divorce
- Termination of the other employment or reduction in the number of hours
- Death of covered person

The employee or dependent must request the special enrollment no later than 30 days from the date of loss of other coverage. The effective date of coverage through the Welfare Fund will be the first day of the first calendar month following the Fund Office's receipt of the completed enrollment form.

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 reserve 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 coverage.
4. 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 active participants may continue coverage for a period of 36 months at the current COBRA rates for themselves and/or your dependent children.

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.

PLUMBERS LOCAL 24 WELFARE FUND – RESIDENTIAL DIVISION
TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **Life Insurance** (active employees only) – $10,000

- **Accidental Death and Dismemberment** (active employees only) – $10,000

- **Medical /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 more information
  - Urgent behavioral health support available 24/7 at 1-800-626-2212

- **Prescription** – **EXPRESS SCRIPTS**
  - See following pages for plan information
  - Call EXPRESS SCRIPTS at 866-716-8340 for more information

- **Dental (active employees only) – Standard plan or Horizon TotalCare Dental Plan**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for more information

PLUMBERS LOCAL 24 WELFARE FUND – RESIDENTIAL DIVISION

SCHEDULE OF BENEFITS

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY DIRECT ACCESS NETWORK with BlueCard

EFFECTIVE DATE: January 1, 2024

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	$6,500	not applicable
Family	$13,000	not applicable
LIFETIME MAXIMUM	unlimited	not applicable
DOCTOR'S OFFICE VISITS		
Primary Care Office Visit	100% after $40 co-pay	not covered
Specialist Office Visit	100% after $40 co-pay	not covered
Maternity Visits	100% after $40 co-pay (applies to 1st visit only)	not covered
Urgent Care	100% after $40 co-pay	not covered
PREVENTATIVE CARE (as defined by the Patient Protection and Affordable Care Act)		
	100% coverage	not covered
DIAGNOSTIC PROCEDURES		
Laboratory	70% coverage	not covered
Radiology	70% coverage	not covered
*Out-of-network tests are not covered except for services rendered by hospital-based pathologists and radiologists at in-network hospitals. $25 co-pay if performed in doctor's office.		
HOSPITAL CARE		
Inpatient Admission	70% coverage	not covered
Inpatient Physician Services	70% coverage	not covered
Surgery in Hospital	70% coverage	not covered
Outpatient Hospital Services	70% coverage	not covered
*Inpatient hospital care requires prior authorization		

	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY CARE		
Emergency Room	70% after $200 copay	70% after $200 copay
*This copay is waived if admitted		
Ambulance	70% coverage	70% coverage
*Covers transport if emergent and medically necessary		
OUTPATIENT SURGERY		
Hospital Outpatient Surgery	70% coverage	not covered
Surgery in Ambulatory SurgiCenter	70% coverage	not covered
BEHAVIORAL HEALTH		
Office Visit	100% after $40 co-pay	not covered
Inpatient	70% coverage	not covered
*Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization		
SUBSTANCE USE DISORDER		
Office Visit	100% after $40 co-pay	not covered
Inpatient	70% coverage	not covered
*Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization		
OTHER SERVICES		
Chiropractic Care Visit	100% after $40 co-pay	not covered
*Up to 30 visits per person per calendar year		
Home Health Care Services	70% coverage	not covered
*Maximum 120 visits per calendar year, 4 hours=1 visit, no custodial care. Prior authorization required.		
Hospice Services	70% coverage	not covered
*For outpatient –maximum 180 days per calendar year, $10,000 lifetime maximum. Excludes respite care, pastoral care and counseling.		
Skilled Nursing Care		
Inpatient	70% coverage	not covered
Outpatient (at home)	70% coverage	not covered
Outpatient (at facility)	70% coverage	not covered
*Maximum 150 days per calendar year. Medical treatment only.		
THERAPY SERVICES		
Occupational Therapy	100% after $40 co-pay	not covered
Physical Therapy	100% after $40 co-pay	not covered

	IN-NETWORK	OUT-OF-NETWORK
Respiratory Therapy	100% after $40 co-pay	not covered
Speech Therapy *30 visits per person per calendar year	100% after $40 co-pay	not covered
All Other Covered Medical Services	70% coverage	not covered

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 Horizon Blue Cross Blue Shield **at least 24 hours prior to admission**.
Emergency admissions must be authorized within 72 hours after hospital admission.

No benefits will be paid for treatment that has not received prior authorization.

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

PROVIDER PHONE RESOURCES: HORIZON MEDICAL & BEHAVIORAL HEALTH

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

In-Network Only

The medical and behavioral health benefits provided under the Plan are **in-network only**.

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

(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.

PLUMBERS LOCAL 24 WELFARE FUND – RESIDENTIAL DIVISION
PRESCRIPTION DRUG BENEFIT
Please call EXPRESS SCRIPTS at 866-716-8340 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 – 60% co-payment
- Non-Preferred Brand Name Drugs – 100% co-payment

The retail prescription co-payment for medications related to the treatment of diabetes, including insulin, biguanides, syringes and needles, and the statin medications used for the treatment of high cholesterol are as follows: Insulin, Biguanides, Syringes, Needles, HMG CoA Reductase Inhibitors
Generic: $0 co-pay; Preferred Brand: $35; Non-Preferred Brand: 50% co-pay, $35 minimum, unlimited maximum.

Mail Order Prescriptions

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

- Generic Drugs – $10 co-payment
- Preferred Brand Name Drugs – 60% co-payment
- Non-Preferred Brand Name Drugs – 100% co-payment

The mail order prescription co-payment for medications related to the treatment of diabetes, including insulin, biguanides, syringes and needles, and the statin medications used for the treatment of high cholesterol are as follows: Insulin, Biguanides, Syringes, Needles, HMG CoA Reductase Inhibitors
Generic: $0 co-pay; Preferred Brand: $70; Non-Preferred Brand: 50% co-pay, $55 minimum, unlimited maximum.

Specialty Medication

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

After $2,600 per person or $5,200 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.

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

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

Standard Dental Plan with your choice of provider:

- Annual Dental Deductible - $0
- Annual Dental Maximum -$1,500/person
- Lifetime Orthodontia Maximum - $1,500/person

OR

Optional Horizon TotalCare Dental Plan

Features of this optional plan include:

- No annual benefit maximum
- No patient paid expenses for basic covered services
- No need to submit claim forms

PLUMBERS LOCAL 24 WELFARE FUND – RESIDENTIAL DIVISION
BENEFIT PLAN MAXIMUMS

Annual Horizon TotalCare Dental Maximum – unlimited

Annual In-Network Medical Maximum Out-of-Pocket Limit-$4,000 person/$8,000 family
(Co-pays, deductibles and co-insurance count towards this out-of-pocket limit)

Annual Prescription Maximum Out-of-Pocket Limit - $2,600 person/$5,200 family
(Prescription co-pays count towards this limit)
For active employees and non-Medicare eligible retired employees only

Annual Standard Dental Plan Maximum - $1,500/person

Chiropractic Care Maximum – 30 visits per person per calendar year

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

Lifetime Hospice Care Maximum – 180 days per calendar year, $10,000 per person. Excludes respite care, pastoral care and counseling

Lifetime Orthodontia Maximum - $1,500/person

Skilled Nursing Care Maximum – 150 days per calendar year. Medical treatment only

Speech Therapy Maximum – 30 visits per person per calendar year

PLUMBERS LOCAL 24 ANNUITY FUND

Effective January 1, 2019

YOUR ACCOUNT BALANCE IS EQUAL TO:

- Employer Contributions, plus
- Investment Earnings, less
- Investment loses, less
- Withdrawals, less
- Expenses of operating the fund

TYPES OF ANNUITY BENEFITS

- Retirement – payable if you are receiving a pension from Plumbers Local 24 Pension Fund or you are totally and permanently disabled from the industry.

- Disability – payable if you become totally and permanently disabled.

- Termination – payable if no employer contributions have been made on your behalf for a continuous 6 month period.

- Death - payable upon death.

- Unemployment – if you are no longer employed under the jurisdiction of the Union for a period of at least 1 week and if you have had a balance in your Individual Account for a minimum of 5 years, you may apply for a portion of your Individual Account in an amount not to exceed 50% of the balance in such account. This amount is only available to participants for the following purposes:

    - Medical expenses of at least $500 which were not payable by Plumbers Local 24 Welfare Fund; or

    - Funeral expenses incurred due to death of a spouse, child or parent; or

    - Education expenses incurred from dependent children's schooling beyond the high school level; or

- Purchase of a new home or cooperative or condominium in which he or she will reside requiring a down payment, contract and title expenses (allowable only once); or

- Home improvement on your primary dwelling place in excess of $15,000; or

- Expenses related to an accident or other natural disaster.

FORMS OF PAYMENT

- Lump Sum

- Monthly installments paid until exhaustion of the Individual Account

- Combination lump sum and monthly installments paid until exhaustion of the Individual Account

- Equal monthly installments over a period of years not to exceed your life expectancy or, if married, the joint life expectancy of you and your spouse

- Combination of lump sum payment and monthly installments over your life expectancy or the joint life expectancy of you and your spouse

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

PLUMBERS LOCAL 24 ANNUITY FUND INVESTMENT OPTIONS

Small Cap Fund

- William Blair

Mid Cap Funds

- American Century Mid Cap Value
- Mass Mutual Mid Cap Growth
- T. Rowe Price New Horizon

Large Cap Funds

- American Funds Fundamental Investors
- ClearBridge Dividend Strategy
- JP Morgan Invst Mgmt
- Mass Mutual Diversified Value
- MM S&P 500 Index
- Vanguard Value Index

International Funds

- American Funds EuroPacific Growth
- iShares MSCI Total International Index
- Lazard Global Listed Infrastructure

Fixed

- SAGIC Diversified Bond

Bond Fund

- Core Bond – Mass Mutual

Balanced Funds

- American Funds Income Fund of America
- Dodge & Cox Balanced

Asset Allocation

- T. Rowe Price Retirement: Balanced, 2010, 2020, 2030, 2040, 2050

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