PLUMBERS & PIPEFITTERS LOCAL UNION 9
WELFARE, PENSION & SURETY FUNDS

QUICK REFERENCE GUIDE

FOR JOURNEYMEN, FOREMEN, APPRENTICES & RETIREES – PLAN A

EFFECTIVE: JULY 1, 2024

Important Notice: This is an outline of the principal plan provisions of the Plumbers & Pipefitters Local Union 9 Welfare, Pension and Surety 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 & PIPEFITTERS LOCAL UNION 9 WELFARE FUND – PLAN A

Effective July 1, 2024

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 12 consecutive months during which you have been credited with 1,400 hours of service (250 hours for apprentices). Upon satisfying this requirement, you will remain eligible for at least one year.

If You Have 1400 Hours (250 Hours for Apprentices) During the Prior:	**You Will Become Eligible:**
December through November	January 1
January through December	February 1
February through January	March 1
March through February	April 1
April through March	May 1
May through April	June 1
June through May	July 1
July through June	August 1
August through July	September 1
September through August	October 1
October through September	November 1
November through October	December 1

Under certain conditions, employees of newly organized employers become initially eligible on the first day of the second calendar month following the completion of 250 hours of service.

To maintain your eligibility thereafter, you must have at least 350 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 350 hours.

If You Have Less Than 350 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 700 hours. This reserve will be drawn upon to maintain your eligibility if you should fail to receive credit for at least 350 hours of service during a subsequent calendar quarter.

If you become disabled while eligible, you will be credited with 27 disability hours for each week that you are disabled up to a maximum of 700 hours for any one continuous period of disability.

Should your eligibility terminate, it will be reinstated provided you are credited with at least 350 hours of service during a calendar quarter which ends within 10 months after your eligibility terminated. Your eligibility will reinstate on the first day of the second month following that calendar quarter during which you meet this 350-hour requirement. If you do not satisfy this reinstatement provision, you will be treated as a new employee and will be subject to the 1,400-hour requirement for initial eligibility outlined above.

Termination Date:	Period of Time to Work a Total of 350 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 350-hour requirement.

If You Are Credited with Your Required 350th 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

SELF-PAY PROVISION

A self-pay option is available to employees who are subject to termination as a result of failing to meet the quarterly eligibility requirement by 100 hours or less. In this event, you have the opportunity to make contributions on your own behalf to the Welfare Fund for the hours necessary to meet the 350-hour requirement at the normal employer hourly contribution rate. For example, if you have 150 hours of service during a calendar quarter, and you have 110 remaining reserve hours, you will have a total of 260 hours towards the requirement of 350 hours leaving you short of the requirement by 90 hours. In this situation, you would be permitted to make a contribution on your own behalf for the 90 hours at the hourly employer contribution rate, to maintain your eligibility for an additional three (3) months.

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. 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:

	Employees Not Available or not Working in the Industry	Employees Available or Working in the Industry
Single	$ 805.00	$ 570.00
Parent/Child(ren)	$1,210.00	$ 860.00
Family	$1,615.00	$1,145.00

ELIGIBILITY RULES - RETIRED EMPLOYEES

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

- You are eligible for benefits under the Welfare Fund as an active employee at the time of your retirement and have been eligible as an active employee for at least 12 of the 15 years prior to your retirement.

- You are receiving a retirement benefit from the Plumbers & Pipefitters Local Union 9 Pension Fund and have earned at least 12 years of credited service under the Plumbers & Pipefitters Local Union 9 Pension Plan.
- Please note that while it is possible to earn more than one year of Pension Fund Credited Service in a Plan year (that begins July 1 and ends the following June 30), a maximum of only 1 year of Credited Service per Plan Year will count towards the Credited Service requirements in the two Welfare Fund eligibility rules above.
- The total of your age last birthday and combined years of pension Credited Service in the Plumbers & Pipefitters Local Union 9 Pension Fund and the Plumbers and Pipefitters National Pension Fund is at least 85 ("Rule of 85"), or you are receiving a disability retirement pension benefit.
- You make the required contributions in the amount established by the Trustees. The required contribution for retirees over age 65, or those receiving disability retirement benefits from the Local 9 Pension Fund, is 8% of the retiree's monthly pension benefit with a minimum required contribution of $100 per month. The required contribution for retirees age 62 to 64 is $300 per month for a retiree with no dependents; $450 per month for a retiree with a spouse who is Medicare eligible; or $600 per month for a retiree with a spouse who is not Medicare eligible or a single retiree with dependent children. The required contribution for early retirees under age 62 is $591.00 for a retiree with no dependents; $886.50 for a retiree with one or more children; or $1,182.00 for a retiree with a family.
- Eligible retirees covered under other group insurance coverage may elect to waive coverage with a one-time opportunity (per lifetime) to re-enter the Plan on a subsequent January 1st.

If you retire and are eligible for the supplemental early retirement benefit under the Local 9 Pension Fund, your accumulated reserve hours will be canceled.

The health insurance provided under the Welfare Fund to retired Medicare eligible individuals is a Group Medicare Advantage PPO plan. This coverage provided by the Welfare Fund requires Medicare eligible individuals to be enrolled in Medicare Part A and B. It's important you or your dependent spouse sign up promptly for Part A and B to avoid gaps in coverage or late enrollment penalties. In general, individuals become eligible for Medicare on the first day of the month upon attainment of age 65, or 24 months after becoming eligible for Social Security Disability benefits, if earlier.

WELFARE FUND COVERAGE FOR RETIREES THAT RETURN TO WORK

After retiring and qualifying for Welfare Fund retiree coverage, your coverage may be suspended if you return to work. Note that to be qualified for Welfare Fund retiree coverage, you must be receiving a retirement benefit from the Plumbers and Pipefitters Local Union 9

Pension Fund. The Plumbers and Pipefitters Local Union 9 Pension Plan has special rules that will suspend your pension benefit if you return to work. If you return to work under the rules of the Pension Plan and your pension benefit is suspended, you will no longer satisfy Welfare Fund retiree eligibility rule #2 above and therefore your eligibility for Welfare Fund retiree coverage will be terminated on the Welfare Fund's next quarterly termination date (February 28, May 31, August 31 or November 30), following the suspension of your monthly pension benefits.

When your Welfare Fund retiree coverage is terminated you will be offered the ability to self-pay for coverage under COBRA. Alternatively, if you continue to do work for a signatory contractor that requires contributions to the Plumbers and Pipefitters Local Union 9 Welfare Fund, you could regain your status as an active participant eligible for Welfare Fund coverage once you meet the Welfare Fund's active quarterly eligibility rules. Once you cease covered work, however, you will automatically be covered again as a Welfare Fund retiree. An important exception is that participants that retire and qualify for a benefit under the Plumbers and Pipefitters Local Union 9 Pension Plan, but do not meet the Welfare Fund's retiree eligibility rules listed above at the time of their initial retirement cannot later satisfy those requirements by returning to work. Your eligibility for Welfare Fund retiree coverage is determined at the time of your initial retirement and cannot be changed by returning to work.

To the extent that you obtain a benefit from the Welfare Fund for which you are not eligible, you shall be required to reimburse the Welfare Fund for the full amount of the claim paid. If you fail to timely reimburse the Welfare Fund and legal action is required, you shall be liable for all legal fees, costs and expenses in addition to the paid claims.

WAIVER OF RETIREE COVERAGE

In order to be eligible for coverage through the Welfare Fund as a retired participant, you are required to make monthly contributions in amounts established by the Trustees. Some retirees are eligible for other group health insurance coverage through the employment of their spouse or their own employment. Retirees are allowed to temporarily waive their coverage under the Plumbers and Pipefitters Local 9 Welfare Fund with a one-time opportunity (per lifetime) to re-enter the Plan on a subsequent January 1st. During the period of time that coverage is waived, no contributions will be collected. This waiver will apply to all dependents, not just the retired participant.

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

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

For each Medicare eligible retiree and/or Medicare eligible spouse of a retiree covered by the Plan, they will have the option to opt-out of the Medicare Advantage PPO Plan and/or Medicare Part D Prescription Drug Plan coverage. The retiree must continue to make the required contribution for the retiree benefits. There will be no reduction in the rate despite the opt-out selection. Retirees and their dependents are allowed to temporarily opt-out of their Medicare Advantage and/or Prescription coverage under the Plumbers and Pipefitters Local 9 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 spouses of active participants may continue coverage for an indefinite period of time at the current COBRA rates for themselves and/or your dependent children. In the case of a surviving spouse who is Medicare Primary, the monthly premium is $394. 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 RETIRED (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 spouses of retired participants may continue coverage for an indefinite period of time at the current COBRA rates for themselves and/or dependent children. In the case of a surviving spouse who is Medicare Primary, the monthly premium is $394. 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.

PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND – PLAN A

TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **LIFE INSURANCE** - Active Employees - $10,000

- **ACCIDENTAL DEATH & DISMEMBERMENT** - Active Employees - $10,000

- **TEMPORARY DISABILITY** - Active Employees
  - Weekly Benefit -$150
  - Waiting Period – 7 days
  - Maximum Benefit Period – 26 weeks

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

- **PRESCRIPTION – EXPRESS SCRIPTS**
  Actives and Non-Medicare Eligible Retirees
  - See following pages for plan details
  - Call Express Scripts at 1-866-716-7331 for more information

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

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

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

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

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

  Your Medicare Coverage Includes:

  - **Group Medicare Advantage PPO Plan** for Medicare Eligible Retirees through RetireeFirst which covers:
    - Medical
    - Vision
    - Hearing

  - **Group Medicare Part D Prescription Plan** through RetireeFirst

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

PLUMBERS & PIPEFITTERS LOCAL UNION 9
WELFARE FUND - PLAN A

BENEFITS
FOR

Active Employees
&
Non-Medicare Eligible Retirees

PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND - PLAN A
SCHEDULE OF BENEFITS
Active Employees and Non-Medicare Eligible Retirees

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY DIRECT ACCESS NETWORK with BlueCard
EFFECTIVE DATE: JULY 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	$2,500	not applicable
Family	$5,000	not applicable
CO-INSURANCE	100%	not covered
LIFETIME MAXIMUM	unlimited	not applicable
DOCTOR'S OFFICE VISITS		
Primary Care office Visit	100% after $30 copay	not covered
Specialist Office Visit	100% after $30 copay	not covered
Maternity Visits	100% after $30 copay (applies to 1st visit only)	not covered
Urgent Care	100% after $30 copay	not covered
PREVENTATIVE CARE (as defined by the Patient Protection and Affordable Care Act)		
	100% coverage	not covered
DIAGNOSTIC PROCEDURES		
Laboratory	100% coverage	not covered
Radiology	100% coverage	not covered

*Out-of-network tests are not covered except for services rendered by hospital-based pathologists and radiologists at in-network hospitals. There will be a $30 copay if services are rendered in a doctor's office.

	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL CARE		
Inpatient Admission	100% coverage	not covered
Inpatient Physician Services	100% coverage	not covered
Surgery in Hospital	100% coverage	not covered
Outpatient Hospital Services	100% coverage	not covered
*Inpatient 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 $30 copay	not covered
Inpatient	100% coverage	not covered
*Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization		
SUBSTANCE USE DISORDER		
Office Visit	100% after $30 copay	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 $30 copay	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 –120 visits per calendar year, 4 hours=1 visit, excludes respite care, pastoral care and counseling		
Skilled Nursing Care		
Inpatient	100% coverage	not covered
Outpatient (at home)	100% coverage	not covered
Outpatient (at facility)	100% coverage	not covered
*Maximum 120 days per calendar year		

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

Prior Authorization Requirements

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

Inpatient Facility Care

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

Outpatient Services

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

Air Ambulance (retroactive)

Gastric Bypass Procedures

Therapy/Testing Services

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

Diagnostic Radiology:

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

Musculoskeletal:

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

Cardiology:

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

Radiation Therapy:

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

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

In-Network Only

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

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

- Visit www.HorizonBlue.com and click "Find a Doctor" and then "Continue as Guest". Select Medical or Behavioral Health if within NJ. Select "Direct Access" for the plan and then enter the city/state or zip code you are seeking and click "Search". If outside NJ, use "Search Nationally" tab. Choose "Location" tab and follow prompts similarly.
- 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 <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 *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

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PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND - PLAN A
PRESCRIPTION DRUG BENEFIT

Active Employees and Non-Medicare Eligible Retirees

Please call EXPRESS SCRIPTS at 1-866-716-7331 for more information

Participating Retail Pharmacy

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

- Generic Drugs – 20% co-payment, $5 minimum/$50 maximum
- Preferred Brand Name Drugs – 20% co-payment, $20 minimum/$50 maximum
- Non-Preferred Brand Name Drugs – 20% co-payment, $35 minimum/$50 maximum

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

After $2,000 per person of out-of-pocket prescription expense during a calendar year, the maximum retail co-payment thereafter is $10 for the remainder of the year.

After $4,100 per person or $8,200 per family of out-of-pocket prescription expenses during a calendar year, there will be no co-payments required for the remainder of the year.

Mail Order Prescriptions

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

- Generic Drugs – 20% co-payment, $10 minimum/$100 maximum
- Preferred Brand Name Drugs – 20% co-payment, $40 minimum/$100 maximum
- Non-Preferred Brand Name Drugs – 20% co-payment, $70 minimum/$100 maximum

Limitation: 90-day supply

After $2,000 per person of out-of-pocket prescription expense during a calendar year, the maximum mail-order co-payment is $20 for the remainder of the year.

After $4,100 per person or $8,200 per family of out-of-pocket prescription expenses during a calendar year, there will be no co-payments required for the remainder of the year.

Specialty Medication

- $35 co-payment

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

The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage (an individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum).

Understanding the Prescription Drug Formulary

The drug formulary utilized by the Welfare Fund is a list of medications published by the Welfare Fund's Pharmacy Benefit Managers. Medications on the list fall into one of the four categories:

Generic Drugs – Generic drugs are the un-branded form of a prescription medication. They use the same active ingredients as brand name drugs and work the same way. The FDA puts all generic drugs through a rigorous, multi-step process to ensure that they are the therapeutic equivalent of their brand name counterparts. That means that a generic drug can be substituted for a brand name drug, and it will produce the same clinical effect while meeting the same safety profile as the brand name drug.

Preferred Brand Name - These brand-name drugs have been identified as the most therapeutically safe and effective options for treatment of most medical conditions. These drugs do not have less-costly generic equivalents because they are sold under a trademarked name.

Non-Preferred Brand Drugs - These products often have either a generic equivalent or a preferred-brand drug alternative.

Specialty Drugs – Specialty pharmaceuticals is a class of prescription drugs that are typically produced through biotechnology (sometimes known as biologicals) and require special patient monitoring and handling, in addition also require unique education prior to use.

DENTAL BENEFIT – *All Active Employees and Retirees*

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

Dental Services with your choice of provider:

- Annual Dental Deductible - $50 per person or $150 per family
- Preventative and Basic Services – 80% after deductible
- Fixed bridgework, crowns, gold fillings and orthodontia – 50% after deductible
- Annual Dental Maximum -$2,000 per person ($1,000 per family for retirees)
- Lifetime Orthodontic Maximum - $2,000/person (If retired, orthodontia counts towards the $1,000 per family annual dental maximum)

OR

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

- No deductibles
- No annual benefit maximum
- Covers preventative, restorative, orthodontic and periodontic care
- No patient paid expenses with the exception of a 24-month maximum for orthodontics of $500 for children/$1,250 for adults
- No need to submit claim forms

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

Hearing Aid and Exam 100% coverage

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

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 $400 per person maximum towards eye exam and glasses/contacts combined
- Maximum benefit payable once every calendar year

PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND - PLAN A

Actives and Non-Medicare Eligible Retirees

BENEFIT PLAN MAXIMUMS

Annual Dental Maximum - $2,000 per person ($1,000 per family for retirees)

Annual DSO Dental Maximum – unlimited

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

Annual Prescription Maximum Out-of-Pocket Limit - $4,100 per person/$8,200 per 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 Aid Maximum – unlimited up to age 15; $2,000 every 36 months for age 15 and over

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

Hospice Services Maximum – For out-patient, 120 visits per calendar year, 4 hours = 1 visit, excludes respite care, pastoral care and counseling

Lifetime Dental Orthodontia Maximum - $2,000 per person
(If retired, orthodontia counts towards the $1,000 per family annual dental maximum)

Lifetime Maximum for surgical procedures performed to correct myopia (near sightedness) or hyperopia (far sightedness) - $2,000

Speech Therapy Maximum – 30 visits per person per calendar year

PLUMBERS & PIPEFITTERS LOCAL UNION 9
WELFARE FUND – PLAN A

BENEFITS
FOR

Medicare Eligible Retirees

PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND - PLAN A
SCHEDULE OF BENEFITS
Medicare Eligible Retirees & Medicare Eligible Spouses of Retirees
Aetna Group Medicare Advantage PPO Plan
Effective Date: January 1, 2023

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

MEDICAL	MEMBER PAYS
Deductible	$0
Medical Maximum Out-of-Pocket	$1,000
Primary Care Visit	4%
Specialist Visit	4%
Inpatient Hospital Care	$0 Per admit
Outpatient Surgery	$0
Inpatient Mental Health & Substance Abuse	$0 Per admit
Outpatient Mental Health & Substance Abuse	4%
Skilled Nursing Facility	$0, Days 1-120
Urgent Care Center	$35
Emergency Room	$50, Waived if admitted
Ambulance	4%
Durable Medical Equipment	4%

ANCILLARY BENEFITS	MEMBER PAYS
Hearing	$0, Routine hearing exam every 12 months $2,000 Hearing aid allowance every 36 months
Vision	$0, Routine eye exam every 12 months $400 Eyewear allowance every 12 months
Podiatry	Compression Stockings, Unlimited Foot Orthotics, Unlimited
Chiropractic	4%, Unlimited
Fitness Benefit	SilverSneakers
Additional Covered Services	Wigs following Chemotherapy

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

PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND - PLAN A
PRESCRIPTION DRUG BENEFIT
Medicare Eligible Retirees & Medicare Eligible Spouses

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

Participating Retail Pharmacy

Group Medicare Part D plan from RetireeFirst

Maximum **30-day** supply

- Generic Drugs - 20% co-payment, $5 minimum/$50 maximum
- Preferred Brand Name Drugs – 20% co-payment, $20 minimum/$50 maximum
- Non-Preferred Brand Name Drugs – 20% co-payment, $20 minimum/$50 maximum

Maximum **90-day** supply

- Generic Drugs – 20% co-payment, $10 minimum/$100 maximum
- Preferred Brand Name Drugs – 20% co-payment, $40 minimum/$100 maximum
- Non-Preferred Brand Name Drugs – 20% co-payment, $40 minimum/$100 maximum

Mail Order Prescriptions

Group Medicare Part D plan from RetireeFirst

Maximum 90-day supply

- Generic Drugs – 20% co-payment, $10 minimum/$100 maximum
- Preferred Brand Name Drugs – 20% co-payment, $40 minimum/$100 maximum
- Non-Preferred Brand Name Drugs –20% co-payment, $40 minimum/$100 maximum

Specialty Medication

Group Medicare Part D plan from RetireeFirst

- $35 co-payment

DENTAL BENEFIT – ***All Active Employees and Retirees***

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- 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

PLUMBERS & PIPEFITTERS LOCAL UNION 9 PENSION FUND

Effective July 1, 2024

IMPORTANT TERMS

- Plan Year - July 1st to June 30th
- Credited Service
    - Effective for hours worked on or after 7/1/24, participants will earn Credited Service in a single Plan year based on the schedule below:

Hours Worked During Plan Year:	Credited Service Earned:
less than 250	0
250 but less than 500	0.25
500 but less than 750	0.50
750 but less than 1,000	0.75
1,000 but less than 1,500	1.0
1,500 but less than 1,600	1.25
1,600 but less than 1,700	1.30
1,700 but less than 1,800	1.35
1,800 but less than 1,900	1.40
1,900 but less than 2,000	1.45
2,000 or more	1.50

It is important to note that Credited Service earned beyond 1.0 years per Plan year will only increase a participant's benefit accrual. The additional Credited Service will **not** count towards eligibility for any Pension or Welfare Fund benefits including normal, early, disability and supplemental Pension Benefits or Welfare Fund retiree coverage.

- For service from 7/1/21 to 6/30/24, 1/4th year of credit for each 250 hours of service up to a maximum of 1 year of credit for 1,000 hours and up to a maximum of 1.5 years of credit for 2,000 hours.

- For service from 7/1/1977 to 6/30/21, 1/4th year of credit for each 250 hours of service up to a maximum of 1 year of credit for 1,000 hours.

- For service prior to 7/1/1977, credit is based upon provisions of prior plans 181, 236, 270, 331, 380 and 432.

- 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 5 consecutive one-year breaks in 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 with five years of participation; or after age 55 with 30 years of credited service
- Early Retirement – payable at age 55 with 10 years of credited service
- Disability Retirement – payable at any age with Social Security Disability, and 5 years of credited service in the 10 years prior to becoming disabled.

NORMAL RETIREMENT BENEFITS

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

- The monthly benefit earned under the Local 181, 236, 270, 331, 380 and 432 Pension Plans prior to 7/1/1977, plus
- $100.00 per month for each year of credited service earned from 7/1/1977 to 6/30/2003, plus,
- $55.00 per month for each year of credited service earned from 7/1/2003 to 6/30/2015, plus,
- $100.00 per month for each year of credited service earned after 7/1/2015.

EARLY RETIREMENT BENEFITS

Same as Normal Retirement amount reduced by 1/6% for each month that you retire prior to age 62. For example, at age 60 your benefit would be reduced by 4%. At age 58 your benefit would be reduced by 8%. At age 55 your benefit would be reduced by 14%.

Plus, $1,000 per month supplement payable until age 62 for employees who first participated prior to 7/1/2007 and whose age last birthday plus years of credited service equals at least 90.

DISABILITY RETIREMENT BENEFITS

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

FORMS OF PAYMENT

- Life Annuity with 60 payments guaranteed
- Life Annuity with 90 payments guaranteed
- Life Annuity with 120 payments guaranteed
- Spouse's Joint and 50% to Survivor (with pop-up)
- Spouse's Joint and 75% to Survivor (with pop-up)
- Spouses' Joint and 100% to Survivor (with pop-up)

PRE-RETIREMENT DEATH BENEFITS

Non-Vested Employee With at Least 2 Years of Credited Service

- $2,000 times years of credited service, payable immediately 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 ½ the amount you would have received at age 55 under the joint and 50% survivor form, or
- $2,000 times years of credited service (maximum 35 years), payable immediately in a lump sum.

Vested Employee Over Age 55

- Lifetime benefit payable to your spouse, equal to ½ the amount you would have received had you retired under the joint and 50% survivor form, or
- Monthly benefit that would have been paid had you retired, payable for 60 months, or
- $2,000 times years of credited service (maximum 35 years), payable immediately in a lump sum.

POST RETIREMENT DEATH BENEFITS

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

- Lump sum payment of $5,000

PLUMBERS & PIPEFITTERS LOCAL UNION 9 SURETY FUND

Effective January 1, 2023

YOUR ACCOUNT BALANCE IS EQUAL TO:

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

TYPES OF SURETY BENEFITS

- Retirement – payable if you are receiving a retirement benefit from the Plumbers & Pipefitters Local Union 9 Pension Plan.

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

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

- Death - payable upon your death.

- Financial Hardship - available if you have had an account for at least one year but not more than the contributions to your account since 1/1/93. Hardship distributions are available up to three times every 24 months for the following purposes:

    - Medical expenses of at least $1,000 incurred by you, your spouse, dependent child, parent or grandchild, which have not been reimbursed by benefits payable under the Plumbers & Pipefitters Local 9 Welfare Fund or any other program of insurance.

    - Tuition and room and board expenses for yourself, your spouse or dependent child to attend an educational institution above the high school level or a school/institution for physically or mentally handicapped or emotionally disturbed children.

    - Purchase of a home, cooperative or condominium apartment for your principal residence for which you have incurred down payment, contract or title expenses.

- If you are delinquent in the making of mortgage or rental payments on your principal residence and as a result, there is an immediate threat that your mortgage will be foreclosed or you will be evicted.

- Funeral expenses incurred due to the death of your spouse, child or parent.

- If you have been involuntarily unemployed and have exhausted all available state unemployment benefits.

- Involuntarily Unemployed and Waiting for New Jersey State Unemployment Benefits Payments (available up to $10,000 per year for participants who have applied and are waiting for New Jersey State unemployment benefits).

- Disability for a period of at least 26 weeks during which you have been unable to engage in gainful employment due to illness or injury.

- Legal fees and expenses of $1,000 or more incurred by you, your spouse, or dependent children in the defense or prosecution of civil or criminal litigation.

- To cover Federal and State Income Taxes due from the Participant that are in excess of your employer withholding as reflected on your Form W-2.

- For payments to avoid the filing of bankruptcy or assignment for benefit of creditors or receivership under State Law.

FORMS OF PAYMENT

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

FEDERAL AND STATE INCOME TAXES

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

INVESTMENT CHOICES:

Stable Value

- SAGIC Core Bond II Fund

Balanced Fund

- T. Rowe Balanced Fund (default)

Large Cap Core

- iShares S&P 500 Index Fund

Large Cap Growth

- American Century Growth Fund
- Fidelity Contrafund
- T Rowe Growth Fund

Large Cap Value

- Columbia Dividend Income Fund

Mid Cap Core

- Vanguard Mid Cap Index Fund

Small Cap Core

- Vanguard Small Cap Index Fund

Target Date

- Vanguard Target Retirement Date Funds (Income, 2020, 2025, 2030, 2035, 2040, 2045, 2050, 2055, 2060, 2065)

International Stock

- American Funds EuroPacific Growth Fund

Investment earnings credited daily. Investment elections may be changed daily.

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