PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND

QUICK REFERENCE GUIDE

FOR NON-BARGAINING EMPLOYEES – PLAN B

EFFECTIVE: JANUARY 1, 2025

Important Notice: This is an outline of the principal plan provisions of the Plumbers & Pipefitters Local Union 9 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.

PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND -PLAN B
NON-BARGAINING EMPLOYEES

Effective January 1, 2025

ELIGIBILITY RULES

If you are a non-bargaining employee of an eligible participating employer, you will become eligible on the first day of the fourth month following your employment. Your eligibility will terminate on the last day of the month, which follows the month for which your employer last makes required contributions.

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 an 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.

COBRA

Following your retirement or 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:

Single	$ 685.00
Parent/Child(ren)	$1,030.00
Family	$1,370.00

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. 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 $394.00. 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.

TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **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 more information

- **PRESCRIPTION – EXPRESS SCRIPTS**
  - See following pages for plan information
  - Call Express Scripts at 1-866-716-7331 for more information

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

- **VISION – 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

- **HEARING – 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

- **BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS - HORIZON BEHAVIORAL HEALTH**
  - 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.

PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND – PLAN B
SCHEDULE OF BENEFITS
Non-Bargaining Employees

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY DIRECT ACCESS NETWORK with BlueCard
EFFECTIVE DATE: JANUARY 1, 2025

MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE		
(Calendar Year)		
Individual	$0	not covered
Family	$0	not covered
ANNUAL OUT-OF-POCKET MAXIMUM – In Network Only		
(Copays, deductibles, and coinsurance count towards this out-of-pocket limit).		
The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage. An individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum.		
Individual	$2,500	not applicable
Family	$5,000	not applicable
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 maximum visits per calendar year, 4 hours=1 visit, excludes respite care, pastoral care and counseling		

	IN-NETWORK	OUT-OF-NETWORK
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		
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	100% after $30 co-pay	not covered
*30 visits per person per calendar year		
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 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 <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.

PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND – PLAN B
PRESCRIPTION DRUG BENEFIT
Non-Bargaining Employees

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

---

* 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

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

Dental Services with your choice of provider:

- Annual Dental Deductible - $50/person or $150/family
- Preventative and Basic Services – 80% after deductible
- Fixed bridgework, crowns, gold fillings and orthodontia – 50% after deductible
- Annual Dental Maximum -$2,000/person
- Lifetime Orthodontic Maximum - $2,000/person

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

HEARING BENEFIT

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

Adults (over 19 years old):

Routine vision screening per person per calendar year	100% after $30 co-pay
Frames/lenses or contact lenses per person per calendar year	Up to $400
Lifetime LASIK (vision correction *surgery*) benefit per person	$2,000

Dependent Children (up to age 19):

Routine vision screening per person per calendar year	100%
Standard frames*/lenses or contacts per person per calendar year	100%

*Standard frame refers to frames that are not designer frames such as Coach, Burberry, Prada and other name brand designers

PLUMBERS & PIPEFITTERS LOCAL UNION 9 WELFARE FUND – PLAN B
BENEFIT PLAN MAXIMUMS

Annual Dental Maximum - $2,000/person

Annual DSO Dental Maximum – unlimited

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

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

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

Lifetime Orthodontia Maximum - $2,000/person

Skilled Nursing Care Maximum – 120 days per calendar year

Speech Therapy Maximum – 30 visits per person per calendar year