San Mateo County Electrical Construction Industry Health & Welfare and Retirement Plan Workshop

September 9, 2023

Thank you for joining us today,
please make sure to mute yourself upon entry.

We ask that you hold all questions until the end.
We will have a Q&A session after each presentation.

Pension

United Administrative Services

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Website
www.ibew617benefits.com

Other Defined Contribution contacts

Recordkeeper/Statements	Website	Phone
NWPS | Kaufmann and Goble Associates	www.nwps401K.com	(844) 629-1949
Investment Consultant	**Company**	**Phone**
Matt Carson	Morgan Stanley Wealth Management	(317) 818-7402

Vesting Requirements

Vesting Requirements

- **Vesting:** You will earn 1/10th of Vesting Service for 100 hours of covered employment in a Plan Year, up to 1.00 Vesting Service credit for a 1,000 or more hours.

- For any Participant who has worked in Covered Employment on or after January 1, 2009, you will be a vested Participant if you have three (3) years of Covered Employment without incurring a permanent break in service.

- For Participants who worked in Covered Employment prior to January 1, 2009, the Plan required five (5) Years of Service.

Eligibility for Benefits

Eligibility for Benefits

When can you receive benefits?

To be entitled to receive your Plan benefits you must terminate your employment and satisfy one of the following requirements:

- **Normal Retirement-Age 65**. You attain age 65, the Plan's Normal Retirement Age, or later if you are not yet vested, at the fifth anniversary of your Participation in the Plan without a Break in Service. You are considered retired when you reach age 65 and work less than 40 hours in a month in the Electrical Construction Industry in San Mateo County. (You will be required to certify under penalty of perjury that you are no longer working in the Electrical Construction Industry in San Mateo.)

- **Early Retirement-Age 55—Thirty Days Without Working.** You attain age 55, the Plan's Early Retirement Age and terminate your Covered Employment, or thereafter, and file a written certification under penalty of perjury that you have terminated or are intending to terminate your Covered Employment and/or any other employment in the electrical industry prior to your benefit commencement effective date.

Eligibility for Benefits - continued

- **Permanent and Total Disability**. Regardless of your age if you are totally and permanently disabled, you may apply for the money credited to your Individual Account. You will be considered totally and permanently disabled only if you are entitled to a Social Security Disability Benefit (Social Security Award).

- **Travelers.** An Employee, known as a Traveler, who terminates employment in the jurisdiction of IBEW 617, with an Individual Account balance of $5,000.00 or less is entitled to a transfer of the entire balance of his or her Individual Account to his her IBEW Home local with a Defined Contribution Plan upon filing an application with the Administration office.

- **Attainment of Age 70.** You are entitled to a partial or total distribution of your individual account with the Plan upon attainment of age 70 even if you continue to work in Covered Employment.

- **Signatory Employer -59 ½.** An owner of a signatory employer who has not had any contributions made to the Plan for six consecutive months is entitled to a distribution of the entire balance upon attainment of age 59 ½ so long he or she has not worked for any non-signatory employer in the electrical industry.

Eligibility for Benefits - continued

- **Terminally Ill Distributions – Elimination of Early withdrawal Penalties.** A Participant who is not working in covered employment who has been determined to be terminally ill (physician certifies the illness or condition reasonably expected to result in death in 84 months or less) is entitled to a distribution of his or her individual account.

- **Residents of Federally Declared Disaster Areas.** A participant living in a federally declared disaster area is entitled to a distribution of up to $22,000 for each declared disaster. The distribution request must be made within 180 days after the date of the federally declared disaster.

- **Caution- Returning to Work after a Total Distribution—3 Year Vesting.** If you retire and receive a complete distribution of your Pension benefits but later return to Covered Employment requiring contributions to the Plan you must again meet the three-year Vesting requirement.

Form of Benefits

Form of Benefits

- **Partial/Total Lump-Sum Distribution**: You may elect a Partial or Total lump sum distribution of your account balance. There is no limit on the number of partial lump sum distributions.

- **Rollover:** You may elect a Partial or Total Rollover of your individual account balance to an IRA of your choice or to another tax-qualified retirement plan that will accept your rollover distribution.

- **Periodic Monthly Distributions:** You may elect a specific monthly payment in $100 increments or more. The periodic payments will terminate when the account has exhausted.

- **Single Life Annuity-Single Participant:** Under federal law the normal form of benefit for a single Participant is a single life annuity, which is a series of monthly pension payments intending to extend for the balance of your life. Under the life annuity option, payments end when you die. A married Participant, with spousal consent, also may select this form of benefit. If you choose this option the Plan will use your Individual Account balance to provide such annuity from an insurance company or other entity at then current market rates, or determine your monthly benefit based on standard life expectancy tables as required under applicable law. Regardless, monthly payments made directly from the Plan will terminate when your Individual Account balance reaches zero even if you live longer than the age projected under the life expectancy tables.

Form of Benefits

- **Joint and Survivor Annuity (50%, 75%, 100%):** A Participant may elect a benefit providing monthly payments during the continued lifetime of and after the death of the Employee but reduced to 50%, 75%, or 100% and payable to the spouse during the spouse's lifetime after the death of the participant.

- **IRS Mandatory Distribution - Age 73**: Pursuant to Internal Revenue Code requirements, upon attainment of April 1 of the year following the date you attain age 73 you will be required to take an annual required minimum distribution.

- **Note:** If you do not rollover your account, distributions are subject to the required 20% mandatory federal income tax withholding.

Death Benefits

The Plan Office will provide you with a beneficiary designation form. If you die before retirement or withdrawal of your Individual Account, your surviving spouse will be entitled to your benefits, unless the surviving spouse has signed a spousal waiver before a notary on forms provided by the Plan. For non-married Participants (and Participants for whom the spouse has signed a waiver of such benefits), benefits will be paid in accordance with your beneficiary designation form. However, If no beneficiary has been designated or no designated beneficiary has survived you, distribution of the balance in your Individual Account will be made to your spouse, if any, and if none, in equal shares to your children, natural or adopted; if none survive you, to your parents; then to your brothers and sisters; finally, to your estate if there are no survivors.

Qualified Domestic Relations Order

Divorce or Child Support Order ("QDRO"). Pursuant to a Qualified Domestic Relations Order, a Court may award a former spouse, child or other dependent a portion or all of your Individual Account. Payment may also be required by a Court order to be paid to a county or state child support agency. The Plan assesses a $500 QDRO administration fee, which is usually shared between the parties ($250 each).

You may contact the Fund office for a sample order that maybe used in the preparation of Qualified Domestic Relations Order.

Application Procedures

You should contact the Trust Fund office to request an application **90 days prior to your retirement date**. You must fully complete the application and return to the Trust Fund office with a copy of the following documents:

- Proof of age for member and spouse (Birth Certificate, Passport or Photo ID with a second form of ID)
- Marriage Certificate (if applicable)
- Divorce Documents (QDRO, Settlement agreement, final judgement)

Please allow 30 business days for processing. All applications are reviewed on an individual case basis.

Q & A

Retire Health & Welfare Plan

United Administrative Services

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(408) 288-4400

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Insurance Benefits on Retiree plan

Rules to qualify

1. Must be at least 55 years old.

2. Must have CURRENT eligibility at the time of retirement.

3. Must have been eligible under the San Mateo Electrical Workers Health Care Benefits Plan, (or another IBEW Local as long as proof of eligibility is provided) for 10 out of the last 15 years "AND" 2 of the last 5 years immediately preceding date of retirement.

4. Currently receiving (or have recently applied for) Pension benefits from San Mateo County Electrical Construction Industry Retirement Trust (IBEW Local 617), or another IBEW Local as long as proof of Pension contributions are provided.

5. If eligible for Medicare, must have Medicare Parts A and B.

6. The medical insurance that you have at time of Retirement is what you will remain on until the next annual Open Enrollment which is in June of each year.

Insurance Benefits on the Retiree plan

For Early Retirees, the two options are the Self Funded PPO Plan and Kaiser. Please note that the Self Funded benefits are slightly different than the Active Plan. (See attached Summary of Benefits) The Kaiser benefits are the same as the Kaiser Active Plan. The Pharmacy benefit for the PPO Plan has a $100 deductible and the Dental and Vision Benefits remain the same.

Once retired, there is **no longer** a Life Insurance benefit.

Once a retiree has Medicare, the two options available are: Blue Shield and Kaiser Senior Advantage. (See attached Summary of Benefits)

Since you will be enrolled in the group pharmacy benefit, you will not need additional pharmacy coverage. Again, the Dental and Vision benefits will remain the same, but there is no Life Insurance benefit.

Insurance Benefits on the Retiree plan

The retiree billing statements are sent out every quarter. It is up to the retiree whether they want to pay a quarter at a time or pay it monthly. Please note, that the payments are due by the 25th of the month prior to the month of coverage; for .... example: Payment for October 2023 coverage is due no later than September 25, 2023. You also have the option to set up automatic payments (bill pay) through your bank.

If you plan on moving out of California prior to age 65, you will not be eligible for the Blue Shield Medicare Supplement Plan or Kaiser Senior Advantage when you become 65 years old and are eligible for Medicare. Your only option will be to enroll in The Hartford Medicare supplement plan. If you choose The Hartford Medicare supplement plan, you will also be enrolled in the SavRx Prescription plan. If you enroll in The Hartford Plan, you will also continue coverage for dental and vision. See attached benefit summary.

Returning to work once retired

Insurance Benefits on the Retiree plan

Once a participant retires, and he returns to work either part time or full time, he will remain in the retiree Health & Welfare Plan. If the retiree works up to 40 hours or less during a calendar month, the Employer contributions made on his or her behalf for the hours worked will be used to offset the required retiree premium, with any remainder to be paid by the participant. If the hours reported for such a Participant (who had previously retired) exceed the hour requirement for retired Participants per calendar month (more than 40 hours), the excess Employer contributions made on the Participants behalf shall be retained by the Plan.

Converting reserved hours to retiree reserve bank

SAN MATEO ELECTRICAL WORKERS

CONVERTING RESERVE HOURS TO YOUR RETIREE RESERVE BANK

When you retire, the Plan office converts your accumulated hours in your hour bank as follows:

Your hours are converted to dollars for purposes of purchasing retiree coverage. For example, if you have a maximum bank of 1440 hours in your hour bank, that is equivalent to twelve months of coverage (12 months x 120 hours = 1440 hours)

The current monthly cost of the Active Plan for a self-funded participant is $1,874.10, and for Kaiser, the monthly cost is $2,183.69. The Plan multiplies $1,874.10 x 12 months, which equals $22,489.20. For Kaiser Participants, the rate of $2,183.69 x 12 months, which equals $26,204.28.

This amount is then used on your behalf to pay the retiree medical premiums for coverage under the Retiree medical plan. (If you have 11 months of coverage and an extra 30 hours, the extra 30 hours are not converted to dollars. The cost of coverage will likely increase each year. Moreover, the Board of Trustees has the right to change the 120 hours required for a month of coverage.

Retiree Rates

SAN MATEO ELECTRICAL WORKERS

RETIREE RATES

EFFECTIVE JUNE 1, 2020

DEFINITION		OLD RATE	NEW RATE
Early Retiree PPO	SINGLE	$480.00	$505.00
Early Retiree PPO w/Spouse under 65	2-PARTY	$841.00	$891.00
Early Retiree PPO w/Spouse over 65	2-PARTY	$771.00	$821.00
Early Retiree PPO Family	FAMILY	$1,033.00	$1,108.00
Early Retiree Kaiser	SINGLE	$350.00	$375.00
Early Retiree Kaiser w/Spouse under 65	2-PARTY	$642.00	$692.00
Early Retiree Kaiser w/Spouse over 65	2-PARTY	$538.00	$588.00
Early Retiree Kaiser	FAMILY	$884.00	$959.00
Early Retiree - Disabled	SINGLE	$136.00	$161.00
Early Retiree - Disabled w/Spouse under 65	2-PARTY	$338.00	$388.00
Early Retiree - Disabled w/Spouse over 65	2-PARTY	$203.00	$253.00
Medicare 65 or Older	SINGLE	$136.00	$161.00
Medicare 65 or Older w/Spouse Under 65	2-PARTY	$338.00	$388.00
Medicare 65-79 w/Spouse Under 65 + Children	FAMILY	$670.00	$745.00
Medicare 65 or Older w/Spouse 65 or Older	2-Party	$203.00	$253.00
Medicare 65-79 w/Spouse 65-79 + Children	FAMILY	$445.00	$520.00

Benefit Summaries

San Mateo Electrical Workers ACTIVES
Anthem Blue Cross PPO Self-Funded Plan Benefit Summary
2023–2024

	LEVEL ONE	LEVEL TWO
	PPO PROVIDERS	OUT OF NETWORK
Deductible – Individual	$0	$250
Deductible – Family	$0	$500
Annual Out-of-Pocket Maximum	The out of pocket maximum is $1,250 per individual and $2,500 per family. Deductible and office visit copayments do not apply to the out of pocket maximum.	The out of pocket maximum is $2,000 per individual and $4,000 per family. Deductible and office visit copayments do not apply to the out of pocket maximum.
Lifetime Maximum	None	None
	BENEFITS FOR COVERED SERVICES	
PHYSICIAN SERVICES		
Office visits	$15 COPAYMENT	$15 COPAYMENT
Hospital/Skilled Nursing visits	90%	60%
Specialists	$15 COPAYMENT	$15 COPAYMENT
Surgeon/Asst. Surgeon	90%	60%
Anesthesiologist	90%	60%
Diagnostic X-ray & Labs	90%	60%
PREVENTIVE CARE		
Routine Physical Exam	100%	60%
Well Baby Care	100%	60%, Covered from birth to age 3
Immunizations	90%, Covered from birth to age 3	60%, Covered from birth to age 3
HOSPITAL/SURGICAL SERVICES		
Inpatient**	90%	60%
Outpatient	90%	60%
EMERGENCY SERVICES		
Ambulance	90%	90%
Emergency Room	90% after $50 copay Waived if Admitted	60% after $50 copay Waived if Admitted
MATERNITY SERVICES		
Hospital Benefits – Delivery**	90%	60%
Outpatient Physician Services	90%	60%
Surgical Services	90%	60%

PRESCRIPTION DRUGS		
Retail Purchase *Limit of 2 fills per medication at a retail pharmacy, not to exceed 30 day supplies for each fill*	$5 Generic/$15 Preferred Brand/$25 Non-Preferred Brand	$5 Generic/$15 Preferred Brand/$25 Non-Preferred Brand
Generic or Brand maximum amount	30 day supply	30 day supply
Save money with Mail Order!	Prescription Drugs are provided by SavRx	
Mail Order Purchase *Required for all maintenance medications, after 2 fills at a retail pharmacy, not to exceed 90 day supplies.*	$10 Generic and $30 Preferred Brand/$50 Non-Preferred Brand	$10 Generic and $30 Preferred Brand/$50 Non-Preferred Brand
Generic or Brand maximum amount	90 day supply	90 day supply
IMPORTANT: The IBEW Local 617 drug plan requires utilization of the mail order pharmacy for medications taken on a long term basis. Copayments increase two fold upon the third prescription fill for any medication not filled by the plan's mail order pharmacy. Copayments are reduced by one third for ninety day supplies obtained through the mail order pharmacy. All new (first time) prescriptions for long term medications should first be filled at a local retail pharmacy for the first two fills, to evaluate efficacy and tolerability, before ninety day maintenance supplies are ordered through the mail order pharmacy.		
SUBSTANCE ABUSE TREATMENT		
	For inpatient or outpatient services for substance abuse treatment, please contact UAS at 408-288-4400.	For inpatient or outpatient services for substance abuse treatment, please contact UAS at 408-288-4400.
Hospital Benefits **	90%, max 30 days per calendar year	60%, max 30 days per calendar year
Outpatient Physician Services	90%*	60% *
MENTAL AND NERVOUS (EXCLUDES SEVERE MENTAL DISORDERS)		
Hospital Benefits **	90%, max 30 days per calendar year	60%, max 30 days per calendar year
Outpatient Physician Services	90%*	60%*
CHIROPRACTIC AND ACUPUNCTURE SERVICES	90%*	60%*
CONTINUED CARE SERVICES		
Home Health Care	90%*	60%*
Skilled Nursing Facility**	Following discharge from an acute care facility, plan pays 90%	Following discharge from an acute care facility, plan pays 60%
PHYSICAL THERAPY	90%*	60%*
SPEECH THERAPY	90%*	60%*

* Note: There is a 30 visit per calendar year limit for these services.
** Note: Precertification of services is required for non-emergency hospital admissions.

Disclosure Form Part One

8972 SAN MATEO ELECTRICAL WORKERS HEALTH CARE BENEFITS PLAN
Home Region: Northern California
6/1/23 through 5/31/24

Principal benefits for Kaiser Permanente Traditional HMO Plan

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call Member Services.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 per visit
Most Physician Specialist Visits	$15 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit

Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	$50 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	$50 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	$10 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	20% Coinsurance

(continues)

Disclosure Form Part One *(continued)*

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$100 per admission
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$100 per admission
Individual outpatient substance use disorder evaluation and treatment	$15 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	the Cost Share you would pay if the Services were to treat any other condition
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

8972 SAN MATEO ELECTRICAL WORKERS HEALTH CARE BENEFITS PLAN

Principal Benefits for
Kaiser Permanente Senior Advantage (HMO) with Part D (6/1/23—5/31/24)

Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:	
For any one Member	$1,000 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$10 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$10 per visit
Urgent care consultations, evaluations, and treatment	$10 per visit
Physical, occupational, and speech therapy	$10 per visit
Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$10 per visit
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$35 per visit
Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share)	
Ambulance Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines	$10 for up to a 100-day supply
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	No charge

(continues)

(continued)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$100 per admission
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$100 per admission
Individual outpatient substance use disorder evaluation and treatment	$10 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
Meals delivered to your home following discharge from a hospital due to congestive heart failure	No charge up to two meals per day in a consecutive four-week period, once per calendar year

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.

PLAN G EXTRA

MEDICARE (PART A)
HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A deductible)	$0
61st through 90th day	All but $389 a day	$389 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 Pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/ Coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G EXTRA

MEDICARE (PART B)
MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 Pints (Part B)	$0	All costs	$0
Next $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES			
	100%	$0	$0

PLAN G EXTRA

PARTS A & B

* Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM			
	$0	100%	$0
PHYSICIAN CONSULTATION BY PHONE OR VIDEO THROUGH TELADOC			
	$0	$0	$0 per consult
OVER-THE-COUNTER ITEMS THROUGH CVS Eligible over-the-counter (OTC) items are available through the OTC Items Catalog, at **blueshieldca.com/medicareOTC. Limitations may apply. Refer to the OTC Items Catalog for more information.**			
Up to two orders per quarter	$0	Up to $100 allowance per quarter	All costs above the $100 allowance per quarter

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES - Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*.			
Comprehensive eye exam once every 12 months	$0	**In-Network:** 100% after the $20 copayment **Out-of-Network:** Up to $50 allowance	**In-Network:** $20 copay **Out-of-Network:** All costs above the $50 allowance
Eyeglass frame once every 24 months	$0	**In-Network:** Up to $100 allowance **Out-of-Network:** Up to $40 allowance	**In-Network:** All costs above the $100 allowance **Out-of-Network:** All costs above the $40 allowance
Eyeglass lenses once every 12 months • Single vision • Bifocal • Trifocal • Aphakic, lenticular monofocal, or multifocal	$0	**In-Network:** 100% after the $25 copayment **Out-of-Network** Single Vision: Up to $43 allowance Bifocal: Up to $60 allowance Trifocal: Up to $75 allowance Aphakic or lenticular monofocal or multifocal: Up to $104 allowance	**In-Network:** $25 copay **Out-of-Network:** All costs above the allowance

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES - Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*.			
Contact lenses (instead of eyeglass lenses) once every 12 months • Non-elective (medically necessary) – Hard or Soft – one pair • Elective (cosmetic/convenience) – Hard – one pair • Elective (cosmetic/convenience) – Soft – Up to a three- to six-month supply for each eye based on lenses selected	$0	**Non-elective In-Network:** Up to $500 allowance after the $25 copayment **Non-elective Out-Of-Network:** Non-elective (Hard or Soft): Up to $200 allowance **Elective In-Network:** Up to $120 allowance after the $25 copayment **Elective Out-Of-Network:** Up to $100 allowance	**Non-elective and Elective In-Network:** $25 copay **Non-elective and Elective Out-Of-Network:** All costs above the allowance

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES - Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at **blueshieldca.com/HearingAids**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
Hearing aid Benefits every year include:			
• One in-person routine hearing exam	$0	100%	$0
• Hearing aid instrument	$0	$0	**Silver Technology Level** $449 per hearing aid **Gold Technology Level** $699 per hearing aid
o Up to two hearing aids delivered in-person through a network hearing aid provider or directly to the member's home depending on the hearing aid type and care delivery method selected			
o Choice of private-labeled Silver (mid-level) or Gold (premium level) technology hearing aid models			
o Silver technology hearing aids: – available in the behind-the-ear hearing aid style only – choice of virtual or in-person delivery			
o Gold technology hearing aids: – available in multiple styles – choice of virtual or in-person delivery – virtual delivery is available for the behind-the-ear and receiver-in-the-ear hearing aid styles			

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES - Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at **blueshieldca.com/HearingAids**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
– in-person delivery is available for the in-the-ear, in-the-canal, completely-in-canal, behind-the-ear, and receiver-in-the-ear hearing aid styles			
– standard ear molds and impressions are available in-person as needed			
o All technology levels include:			
– one consultation			
– up to three follow-up visits for hearing aid fitting, consultation, device check, and adjustment for no additional fee within 12 months of purchase			
– consultation and follow-up visits are delivered in-person or virtually depending on the hearing aid type and care delivery method selected			
– charging case for rechargeable battery models or a two-year supply of batteries per hearing aid; and			
– three-year extended warranty.			

HRA Information

CLAIM FOR REIMBURSEMENT
SAN MATEO ELECTRICAL WORKERS TRUST FUND
HEALTH REIMBURSENT CLAIM FORM

Name _____ Social Security #_____

Street Address _____

City, State, Zip Code_____

Complete only the sections that apply to the claim you are submitting for reimbursement. Part 1 is for Unreimbursed Medical Expenses, Part 2 is for Authorization to Deduct Self Payment Amounts from your HRA Account to continue coverage. Payment for Medical Reimbursement will be issued to you once a month, provided you have a balance in your HRA Account. ***Please note that the HRA Funds are part of the Trust and that an HRA Account balance is not a vested benefit.***

Part 1: UNREIMBURSED MEDICAL EXPENSES - Send Bills, Explanation of Benefits or other documents.

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
PLEASE READ CAREFULLY:			TOTAL AMOUNT CLAIMED:	

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form are for covered medical expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State or City Income Tax on amounts paid from the Plan which relate to such expense. It is the member's responsibility to keep copies of all claim forms and receipts for potential IRS Audits.

The undersigned certifies that the above Medical expenses have not been reimbursed and are not reimbursable under any other health plan coverage.

_____ _____

Employee's Signature **Date**

PART 2: AUTHORIZATION TO DEDUCT SELF PAY PREMIUM FROM EXTENDED RESERVE ACCOUNT

My signature below is authorization to have the monthly premium amount required for Active Member self payment, Retiree Premium or COBRA coverage to be deducted from my HRA Account. I understand that payment deduction from my HRA Account will continue only under the terms of the San Mateo Electrical Workers Health and Welfare Trust Fund rules of Self Payment and COBRA coverage. The authorization is for continuation of coverage as checked below. I may continue Medical Only Coverage or Medical and Dental Coverage. I may not continue Dental Only coverage.

Please check only one option:

I elect deduction of the required Medical Only Coverage: _____

I elect deduction of the required premium for Medical and Dental Coverage: _____

This authorization will remain in effect until the earliest of the following; a) such time as I am no longer eligible to continue coverage under the self pay rules or COBRA coverage, b) my HRA Account balance is exhausted or c) I rescind the authorization in writing. I understand if I rescind this authorization prior to the end of the period allowed by self pay rules, I can not later elect to use the HRA Account for any remainder of that entire period.

_____ _____

Employee's Signature **Date**

Claim Form

(Instructions on next page)

navia benefit solutions

Employee Information

Last Name, First Name	SSN / Employee ID #
Home Address (Street, City, State, Zip Code) ☐ Please update my address on file	**Phone Number**
Employer Name	**Email Address**

Did you know you can submit paperless claims online or via the MyNavia mobile app? Just take a picture and submit!

HRA

Service Date(s)	Type of Service	Provider's Name	Services For Whom	Net Cost
			Total Reimbursement Request $ _____	

Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my HRA, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HRA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HRA which relate to such expense. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse and/or dependents. Note: The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. For further information, please contact your employer. I certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. By providing an email address, I consent to receive all possible communications from Navia Benefit Solutions, agents, and subcontractors regarding the Plan via email. I may withdraw consent at any time without charge by contacting Navia by phone, email, or mail. To update your email address contact Navia Benefit Solutions by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my HRA to be reduced by the amount(s) shown above.

Participant's Signature X_____	Date_____

Claim Form Instructions

1. Complete employee information section. Be sure to write legibly to ensure proper processing.
2. Itemize your expenses in the table provided and attach copies of your documentation.

   Documentation must clearly show the date of service, type of service, and final cost of service. Examples of acceptable documentation include itemized bills/invoices, or the Explanation of Benefits (EOB) from your insurance carrier.

   - If your employer offers an HRA and you are enrolled in a plan that only offers reimbursement for deductible, coinsurance, and/or copays an EOB is required for claim submission.

   Proof of payment is not required in order to reimburse medical/dental/vision services.
3. Be sure to sign the claim form and submit! Please fax, email or mail a signed claim form, but choose one method only.

Submit to:

Email: 105@naviabenefits.com
Fax: Local (425) 709-7125 or Toll-free (866) 831-6222
Mail: Navia Benefit Solutions
PO Box 53250 Bellevue, WA 98015
Phone: Local (425) 452-3421 or Toll-free (866) 897-1996

Claims status is available online. Please allow at least two (2) full business days for Navia to process your claim.

REV 8/5/2022

Short Term Disability

DISABILITY CLAIM NOTICE

ELECTRICAL WORKERS SAN MATEO COUNTY DISABILITY BENEFIT TRUST FUND
UNITED ADMINISTRATIVE SERVICES, P.O. BOX 5057, SAN JOSE, CA 95150-5057

Please answer all questions fully. This will help avoid unnecessary correspondence.

PART I, CLAIMANT'S STATEMENT

(1) Name of Claimant (Please Print) _____ SOC. SEC. _____

(Last) (First) (Middle Initial) Date of Birth _____ Telephone _____

(2) Home Address _____ Marital Status

(No. and Street) (City) (State) (Zip) ❑ Single

❑ Married ___/___/___/___/___

(3) Employed by _____ IBEW Local No. _____

(4) Did disability arise out of your employment? ❑ Yes ❑ No

❑ Foreman
❑ Journeyman
❑ Apprentice

(5) If an accident was involved, when did it happen? Date _____ 20 _____

(a) Where did the accident occur? _____

(b) Give brief description of accident: _____

(6) Date of beginning covered employment in the electrical industry (Local 6,595,617) _____ 20 _____

(7) Date disability began _____ 20 _____ Last day actively at work _____ 20 _____

(8) Date returned to work _____ 20 _____

(9) Are you receiving or are you entitled to receive benefits from any of the following sources because of this disability or period of absence? (Each question must be answered)

Worker's Compensation	❑ Yes ❑ No	Your own or any other disability		Any Federal, State or	
Social Security	❑ Yes ❑ No	Income Plan	❑ Yes ❑ No	Provincial Agency	❑ Yes ❑ No
State Disability Insurance	❑ Yes ❑ No	Railroad Retirement Act	❑ Yes ❑ No	Other Source	❑ Yes ❑ No

If "Yes," give source of such benefits, amount of benefits and frequency of payment (weekly, monthly or lump sum) _____

APPLICANT: Please read carefully as the following makes you liable for payments made to you in excess of those authorized by the Plan

BENEFITS IMPROPERLY PAID: Any benefit paid to a person not entitled thereto shall be owed by him to the Trust. Notwithstanding any other provision of this Trust, over-payments shall be deducted from future benefits payable to the recipient unless the Administrative Committee concludes that requiring such repayment would be inequitable under the circumstances of the case. I further agree that, if I do not make such restitution and the Disability Trust institutes legal action to collect any sums owed to it, I will be liable to the Trust not only for such sums, but also for all costs and expenses, including reasonable attorneys' fees.

I hereby agree that, in the event it is later determined that I received more Disability Benefits than I was entitled to, I will, upon demand by the Electrical Workers San Mateo County Disability Benefits Trust, make restitution in the amount of any such over-payment. I will disclose any retroactive or lump sum payments made of the above or related benefits.

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true, correct and complete. I hereby authorize any physician, or any hospital, to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original. The Trust at its own expense shall have the right and opportunity to examine the person when and as often as it may require during the pendency of a claim hereunder.

Please note that to qualify for the Disability Benefits, you CANNOT be registered on the IBEW Local 617 out of work list.

Benefits will stop with the month that any beneficiary accepts a benefit payment from ANY electrical industry Retirement Plan (e.g., NEBF, IBEW, or the San Mateo County Electrical Industry Retirement Trust). Benefit payments will also stop with the first month that a beneficiary starts to receive regular Social Security benefits, (not Social Security Disability benefits).

Date this Claim Signed _____ Employee's Signature _____

Revised 12/17

ELECTRICAL WORKERS SAN MATEO COUNTY
DISABILITY BENEFITS TRUST FUND

Give to physician who first attended you when disability started

Name of Patient _____ SSN: _____

Present Address _____

Signature of Patient _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT

To be furnished without expense to the Trust:

When did symptoms first appear or accident happen?	Month	Day	20
Date patient ceased work because of disability	Month	Day	20
Date patient was first seen in emergency	Month	Day	20
Date of first attending visit	Month	Day	20
Date of last attending visit	Month	Day	20
How long will patient be continuously totally disabled and unable to work at his trade? (See Job Description below.)	From	Thru _____ (Approximate Date)	
	❑ Indefinite	❑ Permanently	

Diagnosis and Physician's Remarks:

JOB DESCRIPTION

The following job description for Inside Wiremen can be used as a criterion for medical evaluation and analysis of a claimant's disability:

To be an Electrical Industry Inside Wireman requires physical stamina and mental aptitude. Good vision, mechanical ability and finger dexterity are essential. The trade requires climbing, crawling, crouching and working in cramped quarters, carrying loads up to 50 pounds, and the ability to pull wire up to 50 pounds.

Date _____ _____
Physician's Signature

IO Pension

IBEW PENSION BENEFIT FUND

"IO PENSION"

- Earned because of your continuous IBEW membership.
- NOT EMPLOYERFUNDED

✓ Active "A" membership in the IBEW is required for participation in the Plan.

✓ You must no longer be actively employed in the Electrical Industry to start receiving benefits.

TO START RETIREMENT BENEFITS: Contact your Local Union business office 3 months prior to retiring.

✓ Normal Retirement: Age 65 - must have 5 years or more of continuous "A" membership.

✓ Optional Early Retirement: Age 62 - must have 20 years or more of continuous "A" membership.

✓ Disability Pension: Any Age - must have 20 years or more of continuous "A" membership and must have Social Security Disability Award.

Applying for Pension benefits or just have questions?? Contact your Local Union Office.

PLEASE NOTE:
Early Retirees, (under the age of 65) MUST continue to pay the 1.0. Dues to the union in order to remain a member in good standing. Please contact
the Local 617 Union Office for more details.

IBEW PENSION BENEFIT FUND (PBF)*				
	NORMAL	EARLY	**DISABILITY**	**VESTED**
Years of continuous IBEW membership to be eligible	5	20	20	20
Member's Retirement Age	65	62-64	Approximately 38 - 64	65
Restrictions	May not work in the Electrical Industry	May not work in the Electrical Industry	May not work at all	May not work in the Electrical Industry
Disincentives	None	Reduced Monthly Rate	Must await determination of disability	'Loss of Death and Disability Rights
Benefits effective January 1, 2007	$4.50 per month for each. full year of IBEW membership	Same as Normal less 6.66% for each year under age 65	Same as Normal	Same as Normal, less $4.50/mo. for each year Vested applicant is under age 65
Optional Spouse's Benefit	Eligible	Eligible	Eligible	Not Eligible
* Active "A" membership in the IBEW is required for participation in the Plan.				

Q & A