

**IBEW LOCAL UNION 269  
WELFARE, PENSION & ANNUITY FUNDS**

**QUICK REFERENCE  
GUIDE**

**EFFECTIVE: JANUARY 1, 2018**

**Important Notice: This is an outline of the principal plan provisions of the I.B.E.W. Local Union 269 Welfare, Pension and Annuity Plans and is not intended to completely describe the Plan provisions. In the event of any discrepancy between this outline and the Plans, the Plan Documents shall govern. For further information, please review your Summary Plan Description or contact the office of the Administrator, I. E. Shaffer & Co., at P. O. Box 1028, Trenton, NJ 08628. Telephone 1-800-792-3666.**

# **IBEW LOCAL UNION 269 WELFARE FUND**

Effective January 1, 2016

## **ELIGIBILITY RULES**

You will become initially eligible on the first day of the second month following a calendar quarter during which you complete 1,200 hours of service in the prior 12 month period.

Upon satisfying the initial eligibility requirements, you will remain eligible for at least 6 months.

<b>If You Work 1200 Hours Between:</b>	<b>You Will Become Eligible On:</b>	<b>And Remain Eligible Until:</b>
January 1 – December 31	February 1	August 31
April 1 – March 31	May 1	November 30
July 1 – June 30	August 1	February 28/29
October 1- September 30	November 1	May 31

Note: During your first year of eligibility, you will not be eligible for life insurance, accidental death and dismemberment, dental or vision benefits.

## **CONTINUED ELIGIBILITY AND TERMINATION**

To maintain your eligibility after satisfying the initial requirement, you must have at least 300 hours of service each calendar quarter. Your eligibility will terminate on the last day of the second month following the calendar quarter during which you fail to receive credit for at least 300 hours.

<b>If You Have Less Than 300 Hours of Credit Between:</b>	<b>Your Eligibility Will Terminate On:</b>
January 1 – March 31	May 31
April 1 – June 30	August 31
July 1 – September 30	November 30
October 1 – December 31	February 28 (29)

Hours of service in excess of the hours required to establish and maintain eligibility will be placed in a reserve and will accumulate up to a maximum of 600 hours. These reserves will be drawn upon to maintain your eligibility if you should fail to receive credit for at least 300 hours

of service during a subsequent calendar quarter. If you are eligible for benefits as a retired employee, your accumulated reserve hours will be eliminated upon your retirement.

If you become disabled while eligible, you will be credited with 25 disability hours for each week that you are disabled up to a maximum of 600 hours for any one continuous period of disability. If you serve on active duty of the United States military while eligible, you will be credited with 25 hours for each week of active duty service.

**REINSTATEMENT**

Should your eligibility terminate, it will be reinstated provided you are credited with at least 300 hours of service during a calendar quarter and you are not out of employment with a contributing employer for more than 12 months. For purposes of this provision, your termination date will be either the date you terminated as an active employee or the date you terminated from self-pay continuation of coverage under COBRA. Your eligibility will reinstate on the first day of the second month following that calendar quarter during which you meet this 300 hour requirement. If you do not satisfy this reinstatement provision, you will be treated as a new employee and will be subject to the 1200 hour requirement for initial eligibility outlined above.

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

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

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

If you are a non-bargaining employee of an eligible participating employer, you will become eligible on the first day of the month following your employment. Your eligibility will terminate

on the last day of the month that follows the month for which your employer last makes required contributions.

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

- ◆ You have been eligible for benefits under the Welfare Fund as an active employee for at least 16 of the 20 years prior to your retirement.
- ◆ You have attained age 55 or are totally disabled.
- ◆ You are entitled to receive a retirement benefit from the IBEW Local 269 Pension Fund or you have been eligible as a non-bargaining employee.
- ◆ You make the required contributions in the amount established by the Trustees. If you have attained age 65 or are totally disabled, no contribution is required. The required monthly contribution for early retirees under age 65 is as follows:

Single: \$708  
Parent and 1 Child: \$1,224  
Husband & Wife: \$1,224  
Family: \$1,848

If you fail to make the required contributions prior to age 65, you will not be eligible as a retired employee after age 65.

If you or your dependent loses eligibility, self-pay continuation of coverage is available under COBRA for a limited period of time. Your accumulated reserve hours will be applied before self-pay is required. The current monthly self-pay rates under COBRA are:

	<u>Full Plan</u>
Single	\$ 590.00
H/W or Parent/1 Child	\$ 1,020.00
Family	\$ 1,540.00

## **DEPENDENT COVERAGE IN THE EVENT OF YOUR DEATH**

Following your death your dependents will remain eligible for health benefits until the earliest of the following dates:

1. The last day of a period of twelve (12) months following your death or to the extent that your reserve hours are sufficient to maintain your eligibility, whichever is longer.
2. The date your spouse remarries.
3. The date your dependent becomes eligible for similar benefits under other group coverage.
4. The date your dependent children attaining the maximum eligible age

Once the 12 month period of “free” coverage expires, your dependents may continue their coverage under COBRA as described above. If your surviving spouse is eligible for Medicare, the cost of the continued coverage is \$200 per month.

## **TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND**

- ◆ **Life Insurance** (active employees only) – \$20,000
- ◆ **Accidental Death and Dismemberment** (active employees only) – \$20,000
- ◆ **Medical** – See following pages for plan information
- ◆ **Prescription** – See following pages for plan information
- ◆ **Dental** (active employees only)– See following pages for plan information
- ◆ **Vision** – See following pages for plan information
- ◆ **Employee Assistance Program** - Pre-certification required for all in-patient treatment associated with mental/nervous and substance abuse treatment
- ◆ **Medicare Supplement** - Fund pays as a supplement to Medicare. Subject to a calendar year deductible of \$200 per person or \$500 per family. Payable at 80% up to out-of-pocket maximum of \$1,000 per person/\$2,500 per family

**IBEW LOCAL UNION 269 WELFARE FUND**  
SCHEDULE OF BENEFITS

**AETNA PPO NETWORK**  
**EFFECTIVE DATE: JANUARY 1, 2017**

<b>MEDICAL BENEFITS</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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**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	\$4,600	unlimited
Family	\$9,200	unlimited

**\*Medicare Eligible Plan Participants** – Fund pays as a supplement to Medicare subject to a calendar year deductible of \$200 per person or \$500 per family. Payable at 80% to out-of-pocket maximum of \$1,000 per person/\$2,500 per family. Please note that Medicare eligible participants (with the exception of those that are still either actively employed or the dependents of active employees) must enroll in Medicare Parts A & B. The Welfare Fund will enroll these individuals in its own Medicare Part D plan

<b>LIFETIME MAXIMUM</b>	unlimited	unlimited
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**DOCTOR'S OFFICE VISITS**

Primary Care Office Visit	100% after \$20 co-pay	not covered
Specialist Office Visit	100% after \$20 co-pay	not covered
Maternity Visits	100% after \$20 co-pay (applies to 1 <sup>st</sup> visit only)	not covered

**PREVENTATIVE CARE** (as defined by the Patient Protection and Affordable Care Act)

	100% coverage	not covered
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**IN-NETWORK****OUT-OF-NETWORK****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. Participants must use Quest Diagnostics. \$20 co-pay if performed in doctor's office.

**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

**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 from point where stricken to nearest hospital that can provide treatment)		
Urgent Care Center	100% after \$20 co-pay	not covered

**OUTPATIENT SURGERY**

Hospital Outpatient Surgery	100% coverage	not covered
Surgery in Ambulatory SurgiCenter	100% coverage	not covered

**MENTAL HEALTH**

Office Visit	100% after \$20 co-pay	not covered
Inpatient	100% coverage	not covered
*Inpatient requires pre-certification and includes intensive outpatient and sub-acute partial hospitalization		

**SUBSTANCE/ALCOHOL ABUSE**

Office Visit	100% after \$20 co-pay	not covered
Inpatient	100% coverage	not covered
*Inpatient requires pre-certification and includes intensive outpatient and sub-acute partial hospitalization		

**OTHER SERVICES**

Chiropractic Care Visit	100% after \$20 co-pay	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		



**IN-NETWORK**

**OUT-OF-NETWORK**

Hospice Services	100% coverage	not covered
*For outpatient –maximum 120 visits per calendar year. 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. Medical treatment only.		
All Other <u>Covered</u> Medical Services	100% coverage	not covered

## **Pre-Certification Requirements**

All in-patient hospital stays must be pre-certified by **Aetna at 1-888-632-3862**. Emergency admissions must be certified within 72 hours after hospital admission. No benefits will be paid for treatment that is not pre-certified.

All in-patient treatment relative to mental/nervous and substance abuse conditions must be pre-certified by the **Employee Assistance Program at 1-800-527-0035** rather than Aetna. No benefits will be paid for treatment that is not pre-certified.

## **In-Network Only**

The medical coverage provided under the Plan is **in-network only**. The Plan does not provide out-of-network coverage for providers who do not participate in the AETNA PPO network. The only exception is “**emergency**” treatment rendered by an out-of-network provider with “**emergency**” defined as the sudden onset of an illness or injury where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

- ◆ Placing the covered person's life in jeopardy, or
- ◆ Causing other serious medical consequences, or
- ◆ Causing serious impairment to bodily functions, or
- ◆ Causing serious dysfunction of any bodily organ or part.

## **How to Find an AETNA Healthcare Provider**

- ◆ Ask your physician, hospital, lab or other provider
- ◆ Go to Aetna’s website at **www.aetna.com**
- ◆ Call I.E. Shaffer & Co. at 1-800-792-3666

**PRESCRIPTION DRUG BENEFIT – for Actives and Non-Medicare Eligible Retirees**  
**WELLDYNE RX**

**Retail Prescriptions\***

(Mandatory generic substitution) – no dispense as written  
Maximum 30 day supply

- Generic Drugs – \$5 co-payment
- Preferred Brand Name Drugs – 20% co-payment, max. \$100
- Non-Preferred Brand Name Drugs – 40% co-payment
- Specialty Drugs – Preferred – 20% co-payment, max. \$200
- Non-Preferred – 20% co-payment, max. \$250

Maximum 90 day supply

- Generic Drugs - \$10 co-payment
- Preferred Brand Name Drugs – 20% co-payment, max. \$200
- Non-Preferred Brand Name Drugs – 40% co-payment
- Specialty Drugs – n/a

**Mail Order Prescriptions\***

(Mandatory generic substitution) –up to 90 day supply, no dispense as written

- Generic Drugs – \$10 co-payment
- Preferred Brand Name Drugs – 20% co-payment, max. \$300
- Non-Preferred Brand Name Drugs – 40% co-payment

\*After \$2,000 per person or \$4,000 per family of out-of pocket prescription expenses during a calendar year, there will be no co-payments required for the remainder of the year.

If a name brand drug with a FDA approved generic is requested, the total co-pay will be the generic co-pay plus the difference in cost between the brand and generic medications. This penalty is not subject to the maximum co-pay limitations. The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage (an individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum).

## **PRESCRIPTION DRUG BENEFIT – for Medicare Eligible Retirees**

Please call **LABOR FIRST** at 1-866-302-7770 with any questions about Medicare Part D Prescription Benefits

### **Retail Prescriptions**

#### **Group Medicare Part D Plan from Labor First**

Maximum 30 day supply

- Generic Drugs - \$5 co-payment
- Preferred Brand Name Drugs – \$20 co-payment
- Non-Preferred Brand Name Drugs – \$40 co-payment
- Specialty Drugs – 25% co-payment, max. \$250

Maximum 90 day supply

- Generic Drugs - \$10 co-payment
- Preferred Brand Name Drugs - \$40 co-payment
- Non-Preferred Brand Name Drugs - \$80 co-payment

### **Mail Order Prescriptions**

#### **Group Medicare Part D Plan from Labor First**

Maximum 90 day supply

- Generic Drugs – \$10 co-payment
- Preferred Brand Name Drugs – \$40 co-payment
- Non-Preferred Brand Name Drugs –\$80 co-payment

## **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** – An FDA approved drug, composed of virtually the same chemical formula as a brand-name drug.

**Preferred Brand Name** - If a generic medication is not available for your condition, your doctor may prescribe a brand-name medication. Preferred Brand Drugs have been evaluated by physicians and pharmacists at the Pharmacy Benefit Managers and are deemed to be the most cost-effective way to treat a specific condition. These are covered at a slightly higher cost to you than generic drugs but at a lesser cost than the Non-Preferred Brand Drug.

**Non-Preferred Brand Drugs** - In the event you require a prescription medication that is neither generic nor on the Preferred Brand Drug list, you will pay the highest out-of pocket cost for a Non-Preferred Brand Drug.

**Specialty Drugs** – Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

## **DENTAL BENEFIT**

Two options, annual election effective January 1<sup>st</sup> of each year:

### **DELTA DENTAL:**

Annual Deductible: In-Network (Delta Dental) – None

Out-of-Network - \$50/person or \$150/family

Benefit Payable:

In-Network (Delta Dental) – 85% of reasonable and customary charges

Out-of-Network – 80% of reasonable and customary charges

Annual Maximum Benefit - \$2,000/person

Orthodontia Benefit – 80% reimbursement up to a lifetime maximum of \$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 annual benefit maximum
- ◆ 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

## **VISION BENEFIT**

Maximum benefit payable every 12 months

Examination - \$50

Lens: Single - \$35

Bifocal - \$55

Trifocal - \$70

Lenticular - \$120

Contact - \$70

Frames - \$50

## **WELFARE FUND BENEFIT PLAN MAXIMUMS**

**Annual In-Network Medical Maximum Out-of-Pocket Limit**-\$4,600 person/\$9,200 family  
(Co-pays, deductibles and co-insurance count towards this out-of-pocket limit)

**Annual Prescription Maximum Out-of-Pocket Limit** - \$2,000 person/\$4,000 family  
(Prescription co-pays count towards this limit)  
For active employees and non-Medicare eligible retired employees only

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

**Hospice Care Maximum** – 120 visits per calendar year. Excludes respite care, pastoral care and counseling

**Skilled Nursing Care Maximum** – 120 days per calendar year. Medical treatment only

**Hearing Aids** – Up to age 15 – unlimited benefit. Age 15 and older - \$500 every 36 months

**Supplemental Speech Therapy Maximum** – no visitation limit

**Chiropractic Care Maximum** – 30 visits per person per calendar year

**Shingles Vaccine Maximum** – For employees and dependents age 50 and over. Up to \$250, no co-payment. In-network only.

**Lifetime maximum for surgical procedures performed to correct myopia (near sightedness) or hyperopia (far sightedness)** - \$2,500 per person

**Annual Dental Maximum** - \$2,500/person

**Lifetime Dental Orthodontia Maximum** - \$2,000/person

## **IBEW LOCAL UNION 269 PENSION FUND**

Effective January 1, 2011

### **IMPORTANT TERMS**

- ◆ Plan Year - January 1<sup>st</sup> to December 31<sup>st</sup>
- ◆ Credited Service
  - ◇ For service after 12/31/2010, .1 year of credit for each 100 hours of service up to a maximum of 1 year of credit for 1,000 hours.
  - ◇ For service after 1/1/79, 1/4<sup>th</sup> year of credit for each 250 hours of service up to a maximum of 1 year of credit for 1,000 hours.
  - ◇ For service from 1/1/76 to 12/31/78, ½ year of credit for each 375 hours of service up to a maximum of 1 year of credit for 750 hours.
  - ◇ For service from 1/1/57 to 12/31/75, 1 year of credit for 500 hours of work.
  - ◇ For service prior to 1/1/57, credit is based upon either membership in the union or at least 500 hours of covered employment during a year.
- ◆ Vested Service - same as credited service.
- ◆ Vesting - 100% after 5 years vested service.
- ◆ Forfeiture - occurs if prior to becoming vested you incur a period of 5 consecutive 1 year breaks in service.
- ◆ Break in Service - any plan year during which you do not earn any credited service.
- ◆ Reserve Hours - ¼ year of additional credit for each 250 hours of service over 1,000 during a plan year after 1/1/82 up to a maximum of ½ year of credit. Additional credit is applied first to years prior to 1/1/76 in which less than 1 year of credited service was earned in descending order and then to years from 1/1/76 to 12/31/85 in ascending order.

### **TYPES OF PENSION BENEFITS**

- ◆ Normal Retirement – payable at age 62 with 5 years of participation.
- ◆ Early Retirement – payable at age 55 with 5 years of credited service.
- ◆ Disability Retirement – payable at any age, with Social Security Disability, and 10 years of credited service including 5 years in the last 10 years.

### **NORMAL RETIREMENT BENEFITS**

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

- ◆ \$1.00 per month for each full \$137.00 of contributions during a plan year after 1/1/2010, plus
- ◆ \$1.00 per month for each full \$100.00 of contributions during a plan year after 1/1/2003, plus



- ◆ \$1.00 per month for each full \$58.00 of contributions during a plan year from 1/1/1986 to 12/31/2002, plus
- ◆ \$50.00 per month for each year of credited service prior to 1/1/86.

### **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%. There is no reduction in your benefit if the total of your age and years of credited service is at least 85 ("Rule of 85").

Plus, a supplement payable until age 62 equal to your early retirement benefit determined above, provided you have been credited with at least 16 years of credited service during the 20 plan years immediately preceding your retirement, including 3 years of credit during the last 5 years.

### **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
- ◆ Spouse's Joint and 50%, 75% or 100% to Survivor (with pop-up)

### **PRE-RETIREMENT DEATH BENEFITS**

#### **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 spouse's joint and 50% survivor form, or if the commencement date of this benefit would be more than 12 months after your death,
- ◇ \$4,000 times your years of credited service after 1/1/57 payable in a lump sum.

### **Vested Employee Over Age 55**

- ◇ Lifetime benefit payable to your spouse equal to  $\frac{1}{2}$  the amount you would have received had you retired under the spouse's joint and 50% to survivor form, or
- ◇ If you are unmarried, a monthly benefit equal to the benefit you would have received had you retired, payable for 60 months.

### **POST RETIREMENT DEATH BENEFITS**

- ◆ Continuation of monthly benefit based upon form of payment elected at retirement, plus
- ◆ \$2,000

## **IBEW LOCAL UNION 269 ANNUITY FUND**

Effective October 1, 2016

### **Your Account Balance is Equal to:**

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

### **Types of Annuity Benefits**

- ◆ Retirement – payable if age 55 and retired from the Industry.
- ◆ Disability – payable if totally and permanently disabled.
- ◆ Termination – payable if no covered employment over 3 consecutive months (90 days).
- ◆ Death - payable upon death.
- ◆ Financial Hardship - If you have been a participant under the Plan for at least 3 years, you may apply for a withdrawal of up to \$10,000.00. Contributions and earnings credited to your account during the last three plan years are not available for withdrawal. Hardship distributions are limited to once every two years (24 months) and are available for the following purposes:
  - ◇ Unemployment – upon the exhaustion of state unemployment benefits.
  - ◇ Death of a dependent.

### **Forms of Payment**

After retirement, participants may elect to receive their benefits from one of the following forms of payment:

- ◆ Spouse Joint and 50% to Survivor Life Annuity – If you are married, your annuity benefits can be paid to you in the form of a monthly annuity benefit for your lifetime, with the provision that if you are survived by your spouse, they will receive 50% of such monthly annuity benefits for the remainder of his or her lifetime.

- ◆ Lump Sum payment.
- ◆ Monthly installments.
- ◆ By combination of lump sum and monthly installments.

### **Federal and State Income Taxes**

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

### **Investment Choices:**

- ◆ IBEW Local 269 Annuity Fund Stable Value
- ◆ American Beacon Large Cap Value Investor
- ◆ Dodge & Cox Balanced Fund
- ◆ Dodge & Cox International Stock Fund
- ◆ Fidelity Advisor Retirement Date Freedom Funds (Income, 2010, 2015, 2020, 2025, 2030, 2035, 2040, 2045, 2050)
- ◆ Fidelity Contrafund
- ◆ Legg Mason BW Global High Yield Fund
- ◆ MainStay S&P 500 Index Fund
- ◆ Principal Small Cap S&P 600 R5 Fund
- ◆ Vanguard Explorer Fund Admiral Shares
- ◆ Vanguard REIT Index Fund Admiral Shares
- ◆ Vanguard Total Bond Market Index Fund Admiral Shares
- ◆ Victory Integrity Small-Cap Value Y
- ◆ Wells Fargo Growth Admin

All applications for withdrawal are to be obtained and are processed through the Funds office at: 670 Whitehead Road, Trenton, NJ 08648

Investment earnings credited daily. Investment elections may also be changed daily. Access to your account with your PIN 24 hours a day, 7 days a week – [www.ieshaffer.com](http://www.ieshaffer.com) or call (877) 742-3373 (toll-free).