N.W.O. Electrical Administrators, Inc.
TOLEDO ELECTRICAL BENEFIT PLANS
Mailing Address: P.O. Box 60408 • Rossford, Ohio 43460

September 2019

RE: Health & Welfare Plan Changes

Dear Member,

The Board of Trustees of the Toledo Electrical Welfare Fund (TEWF) periodically reviews the plan's policies and procedures and in conjunction with the Plan's professional advisors makes adjustments as needed. This notice is to inform you of the recent changes decided by the Board of Trustees. The following changes are effective January 1, 2020.

- **Self-Pay Rate**- monthly self-pay increase from $1400 to $1450
- **Prescription Benefits** - Please reference the enclosed Summary of Material Modification for changes
- **Spouses who have access to other health care coverage**- Increase from $100 to $120/mo. This applies to single medical & prescription drug coverage only. It does not include premiums for family medical, dental, vision, life, etc.

In addition to completing the enclosed Enrollment Form, members who have a spouse are required to have the "Spousal Eligibility Affidavit" located on the backside completed, as well. Please note that the employer section must be completed by spouse's employer. ***This is required by ALL MEMBERS WITH SPOUSES, regardless of his/her employment status.***

Please return the enclosed form by December 1, 2019 to ensure spousal coverage for the 2020 enrollment year. Keep in mind the cost threshold of $120 applies ONLY to single coverage of medical and prescription drug coverage. Cost threshold does **not** include any premiums for family medical, dental, vision, life insurance, etc.

Feel free to contact the Funds Office at 419-666-4450 or enrollment@electricalfunds.org with any questions about this notice or any other matter.

Regards,

Toledo Electrical Benefit Plans

enclosures

9/1/2019

SUMMARY OF MATERIAL MODIFICATIONS TO THE TOLEDO ELECTRICAL WELFARE FUND

Re: Changes in Prescription Benefits

The Board of Trustees periodically reviews the way in which healthcare is delivered and how the state of the industry affects the Toledo Electrical Welfare Fund ("Fund") and the benefits offered by it. To best serve all participants and beneficiaries in the Fund, the Board must occasionally make adjustments to Fund benefits. Therefore, the following is a summary of the adjustments in the Fund's prescription benefit that the Board has determined to be in the best interests of the Fund. These changes are effective on the dates specified below.

These changes reflect the advice of the Fund's professional consultants, whom the Board retains to ensure that the Fund offers the most clinically effective drugs at the lowest cost to the Fund and to you. The following explains the changes the Board has adopted:

1. **Drugs now excluded from the Fund's formulary:**

   Previously, the following drugs were covered under the Fund's pharmacy benefit. Effective October 1, 2019, they will not be covered for new prescriptions. However, participants currently using these drugs will be grandfathered:

Duexis	Vimovo	Jublia
Kuvan	Pennsaid 2%	Dexilant
Zipsor	Absorica	Nascobal
Halog	Nexium (prescription)	Cambia
Belsomra	Metformin ER Osmotic (Fortamet generic)	Zegerid (prescription, OTC is covered)
Omeprazole-Sodium Bicarbonate (prescription generic Zegerid)	Lorzone	Crestor (generic Rosuvastatin is covered)
Qnasl	Restasis	Horizant
Desloratadine	Dymista	Androgel
HP Acthar Gel	Vyleesi	Levocetirizine
Microsomal triglyceride transfer proteins such as Juxtapid & Kynamro	AuviQ	

   If you are currently taking one of these drugs, contact the Fund Office at 419-666-4450 for information about getting a lower-cost alternative.

2. **Over-the-counter (OTC) drugs available with a prescription:**

   All of the following over-the-counter drugs are now available with a prescription, effective September 1, 2019. These drugs are the same as some of the excluded prescriptions drugs listed above. Note: In order to receive the covered OTCs for $0 copay, you must have a written prescription from your physician with the words "OTC" on the prescription.

All OTC Non-sedating Antihistimines:	***All Proton-Pump Inhibitors (PPIs):***	***Coricosteroid Nasal Spray:***
Allegra	Prilosec OTC	Flonase OTC
Fexofenadine	Prevacid OTC	Nasacort OTC
Cetirizine	Omeprazole OTC	Rhinocort OTC
Zyrtec	Nexium 24HR	Clarispray
Claritin	Zegerid OTC	All generic forms of the above
Loratadine	All generic forms of the above	
Xyzal OTC		
The chewable and pediatric syrups for the above		

3. **Smoking Cessation Limits:**

   Effective September 1, 2019, the Fund will only cover 180 days of tobacco/smoking cessation prescription or over-the-counter products per year.

4. **Drug Quantity Management Program**:

   Effective November 1, 2019, the Fund will implement a program to limit the quantity of certain drugs dispensed per prescription, to ensure that participants are not being over-prescribed certain classes of drugs. Participants currently utilizing these drugs will be grandfathered. Please contact the Fund Office for more information.

5. **Multiple Sclerosis Care Value Program:**

   For participants with Multiple Sclerosis, you will be contacted by the Fund's pharmacy benefit manager, Express Scripts, with additional information and support for your disease. This program will be effective September 15, 2019.

6. **SaveOn Specialty Drug Program:**

   This program will assist participants taking specialty medication by reducing their copayments. If you are currently taking a drug covered by this program, you will be contacted by the Fund's pharmacy benefit manager, Express Scripts, with additional information. This program will be effective November 1, 2019.

   - Certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum. The cost of the Program drugs will be reimbursed by the manufacturer at no cost to the participant.

   - Copays for certain specialty medications may be set to the max of the current plan design or any available manufacturer-funded copay assistance.

Except as specified herein, all other benefits remain unchanged. You may contact the Fund Office at 419-666-4450 if you have any questions about this Summary of Material Modifications, or any other questions about your benefits under the Fund.

Toledo Electrical Welfare Fund
Enrollment Form
419.666.4450 phone 419.666.5410 fax

New Participant ☐ **Change/Add** ☐ **Annual Enrollment** ☐

PARTICIPANT INFORMATION (Please Print) **IBEW CARD #:**

Name | Birth Date | UID or FULL SSN

Address | City | State | Zip Code

Home Phone Number | Cell Number | Email Address

Male ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legal Separation** ☐

Female ☐ **Widow** ☐ **Date of Marriage** _____ **Date of Divorce** _____ **Date of Separation** _____

LIST ALL ELIGIBLE SPOUSE / DEPENDENTS UNDER PARTICIPANT'S TEWF INSURANCE PLAN

Name (Include Last Name if different from participant)	Relationship to Participant Spouse/Daughter/Son	Full SSN	Birth Date	Employed? Yes or NO	Do you have other Health Ins. Primary?

If you marked YES to having other insurance, fill out the section below. Provide a copy of the front & back of your insurance card. If you have a spouse you MUST complete the Spousal Eligibility Affidavit on the other side of this form.

OTHER HEALTH INSURANCE PRIMARY

Name of Insured | Name of Insurance | Policy #

Effective Date | Specify Type of Coverage (e.g.: Medical, Dental, Rx, Vision) | List All Dependents Covered Under This Insurance

I hereby authorize any physician, hospital, insurer, or other organization or person having any records, data, or information concerning health history or medical insurance for me or my family members to furnish such records, data, or information as may be requested by Toledo Electrical Welfare Fund or their duly authorized representative. A photo-copy of this document shall be considered as effective and valid as the original. I Certify that the dependents listed are my dependents as defined by the Health Care Plan, I agree to notify the Fund office if there is a change in any dependent's status such as divorce, birth of a child, etc. I further realize that failure to disclose other insurance cover-age information or to falsify information to the TEWF is considered a fraudulent act against the Fund. A fraudulent act may result in denial of eligibility under the benefit plans.

Signature of Participant | Date

Spousal Eligibility Affidavit

Members enrolling their spouse in the Toledo Electrical Welfare Fund must complete and return this form on a yearly basis, before December 1. **If this form is not completed and returned, your spouse may not be eligible for coverage.**

If your spouse is eligible for medical and prescription drug insurance through their employer at a cost of $120 or less per month, they must elect that insurance as primary. This cost threshold applies ONLY to medical and prescription, not dental, vision, life, etc. coverage. Failure to do so may result in the rescission of their coverage through TEWF.

SECTION I: SPOUSE TO COMPLETE

Spouse's Name: _____

1.	Are you employed, or otherwise eligible for group medical / prescription drug coverage (i.e. Employer Sponsored, COBRA, Early Retiree)?	Yes	No

If "No," skip to Section III of this form.

2.	Are you eligible for coverage under your employer's plan?	Yes	No
3.	If you answered "No" to question 2, please indicate why: _____		
4.	Are you currently enrolled in any other medical plan?	Yes	No
5.	If you answered "Yes" to question 4, please indicate what plan (i.e. employer, trade association, COBRA, early retiree medical coverage through a former employer, etc.): _____		

SECTION II: SPOUSE'S EMPLOYER TO COMPLETE

Name of employer:

_____

1.	Is the above employee eligible for medical and prescription coverage through your company?	Yes	No
2.	Is the employee's cost for the least expensive option for single/employee-only medical and prescription coverage $120 or less per month?	Yes	No
3.	Please indicate the type of coverage for the least expensive option for single/employee-only medical and prescription coverage: ☐ PPO ☐ HMO ☐ High-Deductible ☐ Other (please describe): _____		
4.	Does your company provide an HRA or HSA to your employees in conjunction with the lowest employee-cost option?	Yes	No
5.	If "Yes," what is the employer-provided contribution (if any) to the account? _____		
6.	If the lowest employee-cost option is a high deductible health plan, what is the deductible for that option? _____.		

Please Note: A copy of the enrollment form, benefits summary or other document showing the plan options and employee's share of the premium for medical/prescription coverage option(s) must accompany this affidavit, or no coverage through TEWF shall be available.

Employer Signature: _____ Date: _____

Printed Name: _____

SECTION III: MEMBER TO COMPLETE

Member Name: _____

Member UID or last 4 of SSN: _____

I certify that the above information is true, correct and current under penalty of perjury. I understand that it is my responsibility to inform Toledo Electrical Welfare Fund of any change in my spouse's insurance eligibility status.

Member Signature: _____

Please return completed form to: TEWF, P.O. Box 60408, Rossford, OH 43460 or email to: enrollment@electricalfunds.org