
# TOLEDO ELECTRICAL WELFARE FUND
# SELF-FUNDED PLAN

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# DOCUMENT AND SUMMARY PLAN DESCRIPTION
# ACTIVES – PLAN A
# BASE PLAN – PLAN B
# EARLY RETIREES – PLAN R
# NORMAL RETIREES – PLAN M

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Restated Effective January 1, 2020

# Toledo Electrical Welfare Fund

727 Lime City Road, Suite 200
P.O. Box 60408
Rossford, Ohio 43460
(419) 666-4450

| The Board of Trustees Members (as of 1/1/2020) | |
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**TO ALL ELIGIBLE PARTICIPANTS**:

The Board of Trustees of the Toledo Electrical Welfare Fund ("Plan") is pleased to provide you with this booklet, which describes all the benefits currently available to you and your eligible dependents under the Plan.

The booklet contains important information about the Plan's eligibility rules, coverage and benefits, limitations and exclusions, and rules for filing claims for benefits. Terms which are capitalized are generally defined in the "Definitions" section of this booklet.

**Please Note:**

- The Plan has contracted with FrontPath Health Coalition to participate in their PPO Network, which provides you access to comprehensive health care benefits and services through their PPO Network of physicians, hospitals, laboratories, specialists and other health care providers. You have the option to choose your own personal physicians, specialists, and hospital facility from the comprehensive provider network directory. If you do not utilize network providers, you may be responsible to the provider for charges that exceed the amount covered by the Plan ("Balance Bill").

- All PPO Network hospitals have agreed to provide specific services at a guaranteed rate, so you will receive the maximum benefit amount by having your physician select a PPO Network hospital. All PPO Network physicians have admitting privileges at a PPO Network hospital.

- Most Inpatient care is reviewed before you go into a hospital or other treatment facility. This procedure is called preadmission review; the Plan contracts with America Health Holdings to perform these reviews, as well as utilization review and managed care. **ALL ELECTIVE HOSPITAL ADMISSIONS MUST BE REVIEWED AND CERTIFIED BY AMERICAN HEALTH HOLDINGS.** When you choose a network hospital, the hospital will take care of the preadmission review and notification process for you.

- **WHEN USING A NON-NETWORK OR OUT-OF-STATE HOSPITAL, YOU HAVE THE RESPONSIBILITY TO CONTACT AMERICAN HEALTH HOLDINGS PRIOR TO AN ELECTIVE ADMISSION.**

In Medical Emergency situations always go to the nearest hospital for evaluation or treatment. Emergency care is covered in any hospital, regardless of location and/or network status, and you will not be required to pay the higher out-of-network coinsurance.

The Trustees have complete authority to construe and interpret the provisions of this Plan and Summary Plan Description, and Trust Agreement. Any questions or interpretations about the Plan or Trust Agreement, or disputes about eligibility for or amount of benefits, shall be resolved by the Board of Trustees. No Employer or Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or Trust Agreement. Any interpretation of the Plan or Trust Agreement made by the Trustees will, subject to the claimant's right to legal action, be final and binding on the Participant, Plan, and the Trustees.

If you have any questions about the Plan or need assistance in filing a claim, contact the Fund Office.

Sincerely,

Board of Trustees

This booklet is a copy of the Plan document, and serves as a Summary Plan Description. Plan documents also include any Plan Amendments, rules and regulations, and insurance certificates and riders. The Plan Amendments, rules and regulations, insurance certificates and riders are available at the Fund's administrative office.

## — IMPORTANT NOTICES —

- IT IS IMPORTANT that you immediately contact the Fund Office to:
  - Fill out a BENEFICIARY FORM naming or updating your beneficiary.
  - Change your beneficiary when you desire.
  - Change your home address whenever you move.
  - Add a new dependent when acquired.
  - Report divorce or other change of status.
  - Notify the Plan that you are receiving WORKERS' COMPENSATION BENEFITS.
  - Notify the Plan if you or a dependent becomes eligible for Medicare.
- This Plan is intended to operate in compliance with the Patient Protection and Affordable Care Act and limits in-network out-of-pocket expenses for essential health benefits not-to-exceed the prevailing annual dollar limit under the law, which may change from time to time

## SUMMARY PLAN INFORMATION

Plan Name
Toledo Electrical Welfare Fund

Plan Sponsor
Board of Trustees, Toledo Electrical Welfare Fund
727 Lime City Road, Suite 200
P.O. Box 60408
Rossford, Ohio 43460
EIN: 34-4441661

Plan Administrator
Board of Trustees, Toledo Electrical Welfare Fund
727 Lime City Road, Suite 200
P.O. Box 60408
Rossford, Ohio 43460
EIN: 34-4441661

Plan Year
The Plan Year begins on January 1st and ends on December 31st.
Plan records are maintained on that basis.

Effective Date
The Plan was most recently restated effective January 1, 2020

Administration and Funding
Benefits under the Plan are paid from its general assets and administered by the Board of Trustees.

Agent for Legal Process
Administrative Manager
Toledo Electrical Welfare Fund
727 Lime City Road, Suite 200
P.O. Box 60408
Rossford, Ohio 43460

## YOUR PROVIDERS FOR CLAIM SERVICE

### CLAIMS AND BENEFIT QUESTIONS

| | |
|---|---|
| For **eligibility questions**, questions about **benefits**, and **claims**. | **Fund Office**<br>(419) 666-4450, or visit www.electricalfunds.org |

### MANDATORY PRECERTIFICATION

| | |
|---|---|
| **Prior Authorization for Medical Claims, Managed Care Review** | **American Health Holdings**<br>1 (855) 248-1858, or visit<br>www.americanhealthholding.com |
| **Prior Authorization for Prescription Drug Claims** | **Express Scripts**<br>1 (800) 753-2851, or visit www.express-scripts.com |

### BENEFIT NETWORKS

| | |
|---|---|
| **PPO Network Providers** | **FrontPath Health Coalition**<br>1 (888) 232-5800, or visit www.frontpathcoalition.com |
| **Prescription Drug Claims** | **Express Scripts**<br>1 (877) 797-9688 (for Plan M only, (877) 788-5814), or visit www.express-scripts.com |
| **Dental Claims** | **Delta Dental**<br>1 (800) 524-0149, or visit www.deltadental.com |
| **Vision Claims** | **Vision Service Plan**<br>1 (800) 877-7195, or visit www.vsp.com |
| **Participant Assistance Program/EAP** | **Support Linc**<br>1 (888) 881-5462, or visit www.supportlinc.com |

### APPEALS

| | |
|---|---|
| **All Appeals (Except Prescription)** | **Fund Office**<br>(419) 666-4450 (phone), (419) 666-5410 (fax),<br>claims@electricalfunds.org |
| **Prescription Drug Appeals** | **Clinical Appeals Department, Express Scripts**<br>PO Box 66588<br>St. Louis, MO 63166-6588<br>Fax: (877) 852-4070<br>Phone: (800) 753-2851 |

**Tip:** The Plan, including the above providers, changes from time to time. Please review our website at www.electricalfunds.org for any important changes.

# I. ELIGIBILITY

## Eligibility in General

The eligibility process has 2 steps: Initial Eligibility and Continuing Eligibility. An Active Employee only has to meet the Initial Eligibility rules once. Thereafter, the Active Employee must complete an enrollment form and meet the Continuing Eligibility rules in order to receive benefits under the Plan. See Section VI for a detailed description of the benefits available under the Plan.

Once an Active Employee establishes Eligibility, he or she must meet the rules for Continuing Eligibility as explained below. Otherwise, he or she may have to reestablish Eligibility to receive benefits.

Journeymen, Inside Apprentices, Teledata Employees (Divisions 3 through 6) and Class 26 (Non-Bargained) Employees are eligible to participate in Plan A – Active Employees. Residential Trainees (3rd through 8th Periods) and Teledata Apprentices (1st and 2nd Divisions) are eligible for Base-only Benefits (Plan B). Early Retirees are covered under Plan R. Normal Retirees are covered under Plan M. Each of these plans of benefits are described in detail later in this Plan and Summary Plan Description. Additional information may be found on the website electricalfunds.org or by contacting the Fund Office at (419) 666-4450.

*Please note*: 1st and 2nd Period Residential Trainees are not covered under the Plan. Eligibility for the various Benefits provided under this Plan depends on the Employee's classification, along with other applicable rules. These rules are set forth in the Section describing that particular Benefit.

*Eligible Dependents:*

Eligible Dependents may not participate in the Plan directly. However, Eligible Dependents may receive benefits from the Plan through a Member's participation. Eligible Dependents include:

- The Spouse of the Participant unless the spouse has access to other health coverage that costs $120 or less per month; and
- A child of the Participant who is not in active military service and is under the age of 26.

Spouses who have access to other group health insurance with monthly premiums of $120 or less per month must select that coverage as primary. Spouses who must select that other coverage will still be eligible for secondary coverage under the Plan. Contact the Fund's Office for more information.

## Eligibility for Active Employees

*Initial Eligibility:*
*Active Employees (Journeymen)*: Active Employees are covered under a Collective Bargaining Agreement and do not regularly attend classes at the JATC (i.e., have "topped out"). An Active Employee and his Eligible Dependents are eligible for Benefits on the first day of the third calendar month after the Employee has worked a total of 420 hours in Covered Employment within 3 consecutive Work Months.

**Tip:** Work months are not the same as calendar months. A work month is a 4- or 5-week period beginning on a Monday and ending on a Sunday.

*Eligibility of Newly Organized Employees*:
Notwithstanding the above, a newly organized Employee and his Eligible Dependents are eligible for Benefits commencing on the first day of the calendar month after the Employee has worked 300 hours in covered employment.

*Passage of the Inside Wireman's Examination*:
Notwithstanding the above, a Construction Employee (as defined within NECA/IBEW Family Medical Care Plan) that passes the Inside Wiremen's Examination shall be eligible for coverage immediately upon referral, provided that the Construction Employee has worked at least 300 hours in Covered Employment immediately prior to the referral.

*Continuing Eligibility:*
In order to continue eligibility in the Plan, an Active Employee must work 300 or more hours over 3 consecutive Work Months. This rolling 3-month period begins with the Work Month after the Active Employee began employment. One 3-month period determines eligibility 2 months later, as described in this chart:

| Hours Worked Over the 3-Month Test Period | Establishes Eligibility for the Month |
|---|---|
| January/February/March | June |
| February/March/April | July |
| March/April/May | August |
| April/May/June | September |
| May/June/July | October |
| June/July/August | November |
| July/August/September | December |
| August/September/October | January |
| September/October/November | February |
| October/November/December | March |
| November/December/January | April |
| December/January/February | May |

If an Active Employee does not meet the 300 hour requirement, he or she can maintain eligibility in the Plan by making Self-Payments. The rules regarding Self-Payments are described on page 14 of this Section I. When an Active Employee is making Self-Payments, the rolling 3 month average continues.

*Reciprocity:*
Hours worked by Employees under a reciprocity agreement entered into by the Board of Trustees shall be credited according to the terms and provisions of such reciprocity agreement.

*Termination of Active Employee Eligibility:*
Eligibility for Benefits as an Active Employee terminates upon the earlier of the following events. Termination of the Active Employee's eligibility also results in the termination of eligibility for his or her Eligible Dependents.

- Failure to work the minimum required hours during any 3 consecutive Work Months as set forth above, without eligibility to or having exhausted his right to make self-payments

(see "Self-Payments" for a discussion of self-payment rules); coverage ends on the last day of eligibility due to insufficient employer or self-pay contributions;
- Failure to make a self-payment by the applicable due date; coverage ends on the last day of eligibility due to employer or self-pay contributions;
- The date the Active Employee becomes entitled to Benefits as an Early Retiree, Normal Retiree, or a Totally and Permanently Disabled Employee;
- The date the Active Employee enters active military service;
- The date the Active Employee is incarcerated;
- The date the Active Employee dies;
- The date the Plan is terminated; or
- Such other event or occurrence set forth in the Plan that results in the Active Employee's termination of eligibility.

Termination of the Active Employee's eligibility also results in the termination of eligibility for his or her Eligible Dependents. In the event of an Active Employee's death, Benefits for Eligible Dependents of the Active Employee shall terminate at the end of the calendar month in which the Active Employee dies.

*Reinstatement of Eligibility:*
If an Active Employee loses eligibility because he or she fails to meet the *Continuing Eligibility* requirements detailed above and cannot or does not make self-payments pursuant to the rules summarized below, the Active Employee may reinstate eligibility as an Active Employee on the first day of the third calendar month after working at least 300 hours in Covered Employment over the course of 3 consecutive Work Months. Reinstatement must occur within 12 months after the date the Active Employee first loses eligibility, or he or she must satisfy the normal initial eligibility rules (i.e., 420 hours over a 3-month period).

**Eligibility for Inside Apprentices/Teledata Apprentices (Div. 3-6)**

*Initial Eligibility:*
An Inside Apprentice or Teledata Apprentice (Div. 3-6) and his Eligible Dependents are eligible for Benefits upon the satisfaction of the following conditions:
- The Indentured Apprentice is certified by the Administrative Manager of the Local No. 8, I.B.E.W. Joint Apprenticeship and Training Plan and Trust as an Indentured Apprentice; and
- The Indentured Apprentice's starting date of Covered Employment.

*Continuing Eligibility:*
In order to continue eligibility in the Plan, an Indentured Apprentice must work 300 or more hours over 3 consecutive Work Months. This rolling 3 month period begins with the Work Month after he or she begins employment. One 3 month period determines eligibility 2 months later, as shown in this chart:

| Hours Worked Over the 3-Month Test Period | Establishes Eligibility for the Month |
|---|---|
| January/February/March | June |
| February/March/April | July |
| March/April/May | August |
| April/May/June | September |
| May/June/July | October |

| | |
|---|---|
| June/July/August | November |
| July/August/September | December |
| August/September/October | January |
| September/October/November | February |
| October/November/December | March |
| November/December/January | April |
| December/January/February | May |

If an Indentured Apprentice does not meet the 300 hour requirement, he or she can maintain eligibility in the Plan by making Self-Payments. The rules regarding Self-Payments are summarized below. When an Indentured Apprentice is making Self-Payments, the rolling 3 month average continues.

*Termination of Eligibility:*
Eligibility for Benefits as an Indentured Apprentice terminates upon the earlier of the following events.

- 12:00 midnight on the day on which the Indentured Apprentice either ceases to be certified as an Indentured Apprentice or becomes certified as a journeyman wireman;
- The date the Indentured Apprentice becomes entitled to Benefits as an Early Retiree, Normal Retiree, or a Totally and Permanently Disabled Employee;
- The date the Indentured Apprentice enters active military service;
- The date the Indentured Apprentice dies;
- The date the Plan is terminated;
- Such other event or occurrence set forth in the Plan that results in the Indentured Apprentice's termination of eligibility; or
- The Indentured Apprentice does not, has exhausted the right to, or is not eligible to make the required self-payments.

In the event of an Indentured Apprentice's death, Benefits for Eligible Dependents of the Indentured Apprentice shall terminate at the end of the calendar month in which the Indentured Apprentice dies. Otherwise, benefits for Eligible Dependents shall terminate when the Indentured Apprentice's eligibility terminates in accordance with this section

*Reinstatement of Eligibility:*
If an Indentured Apprentice loses eligibility because he or she fails to meet the *Continuing Eligibility* requirements detailed above and cannot or does not make self-payments pursuant to the rules summarized below, the Indentured Apprentice may reinstate eligibility as an Indentured Apprentice on the first day of the third calendar month after working at least 300 hours in Covered Employment over the course of 3 consecutive Work Months. Reinstatement must occur within 12 months after the date the Indentured Apprentice first loses eligibility, or he or she must satisfy the normal initial eligibility rules (i.e., 420 hours over a 3-month period).

**Eligibility for Residential Trainees (Per. 3-8)/Teledata Apprentices (Div. 1-2); Cable Pullers**

Residential Trainees (3rd through 8th Periods), Teledata Apprentices (1st and 2nd Divisions), and Cable Pullers are eligible for Base-only Benefits. Please note that 1st and 2nd Period Residential Trainees are not eligible for Benefits.

*Initial Eligibility:*
A Residential Trainee (Per. 3-8) or Teledate Apprentice (Div. 1-2) and his Eligible Dependents are eligible for Benefits upon the satisfaction of the following conditions:

- The Trainee or Apprentice is certified by the Administrative Manager of the Local No. 8, I.B.E.W. Joint Apprenticeship and Training Plan and Trust as a Trainee or Apprentice; and
- The Trainee or Apprentice's starting date of Covered Employment.

Cable Pullers are eligible for Benefits upon commencing employment.

*Continuing Eligibility:*
A Residential Trainee (Per. 3 through 8) and Teledata Apprentices (Div. 1 and 2) will continue to participate in the Plan as long as they remain in good standing with the JATC program.

For Cable Pullers to continue eligibility in the Plan, he or she must work 300 or more hours over 3 consecutive Work Months. This rolling 3 month period begins with the Work Month after the Cable Puller began employment. Each 3 month period determines eligibility 2 months later, as shown below.

| Hours Worked Over the 3-Month Test Period | Establishes Eligibility for the Month |
|---|---|
| January/February/March | June |
| February/March/April | July |
| March/April/May | August |
| April/May/June | September |
| May/June/July | October |
| June/July/August | November |
| July/August/September | December |
| August/September/October | January |
| September/October/November | February |
| October/November/December | March |
| November/December/January | April |
| December/January/February | May |

If a Cable Puller does not meet the 300 hour requirement, he or she can maintain eligibility in the Plan by making Self-Payments as described on page 14. When a Cable Puller is making Self-Payments, the rolling 3 month average continues.

*Termination of Eligibility:*
Eligibility for Benefits as Residential Trainee (Per. 3-8) or Teledate Apprentice (Div. 1-2) terminates upon the earlier of the following events.

- 12:00 midnight on the day on which the Trainee or Apprentice either ceases to be certified as a Trainee or Apprentice or becomes certified as a journeyman;
- The date the Trainee or Apprentice becomes entitled to Benefits as an Early Retiree, Normal Retiree, or a Totally and Permanently Disabled Employee;
- The date the Trainee or Apprentice enters active military service;
- The date the Trainee or Apprentice dies;
- The date the Plan is terminated;
- Such other event or occurrence set forth in the Plan that results in the Trainee or Apprentice's termination of eligibility; or

- The Trainee or Apprentice does not, has exhausted the right to, or is not eligible to make the required self-payments.

In the event of a Trainee or Apprentice's death, Benefits for Eligible Dependents of the Trainee or Apprentice shall terminate at the end of the calendar month in which the Trainee or Apprentice dies. Otherwise, benefits for Eligible Dependents shall terminate when the Indentured Apprentice's eligibility terminates in accordance with this section

*Reinstatement of Eligibility:*
If a Residential Apprentice (Per. 3-8) or Teledata Apprentice (Div. 1-2) loses eligibility, he or she may recommence participation in the Plan by returning to work and be certified in good standing by the JATC.

If a Cable Puller loses eligibility, he or she may recommence participation in the plan on the first day of the month after the Cable Puller returns to work and works at least 300 hours in Covered Employment over the course of 3 consecutive Work Months. These 300 hours must be earned sometime within 6 consecutive Work Months. In addition, this requirement must be met within 12 months after the date the Cable Puller first loses eligibility. If a Cable Puller does not meet the reinstatement rules, he or she can regain eligibility in the Plan by satisfying the normal initial eligibility rules (i.e., 420 hours over a 3 month period).

**Eligibility for Class 26 Employees**

*Employer Participation:*
A Class 26 Employee (i.e., non-bargaining) can participate in the Plan if his or her Employer executes and complies with the provisions of a Participation Agreement with the Board of Trustees.

Subject to rules and regulations as may be promulgated by the Board of Trustees from time to time, an Employer may contribute to the Plan either on behalf of all or none of the Employer's Class 26 Employees. The Board of Trustees reserves the right to:

- Refuse to accept as Plan Participants any persons who are not members of a common working unit;
- Expel any person who is not an Employee and/or member of a common working unit;
- Limit participation by Class 26 Employees as necessary to ensure that participation by non-bargaining unit employees does not adversely affect the Plan's tax exempt status under Code Section 501(c)(9); and/or
- Take such other action from time to time as the Board of Trustees believes might be necessary or appropriate.

*Initial Eligibility:*
Class 26 Employees and their eligible Dependents are eligible to participate in the Plan on their date of hire. However, the following Class 26 Employees are not eligible to participate in the Plan:

- Partners, owner-operators, self-employed persons, or any other person failing to constitute an "employee" under the Taft-Hartley Act; and
- Part-Time Employees.

Class 26 Employees and their Employer must follow the rules in the Participation Agreement executed by the Employer to maintain continued eligibility in the Plan.

*Termination of Eligibility:*
Eligibility for Benefits as a Class 26 Employee terminates as of the earlier of the following:

- The Employer fails to pay the required contribution;
- The last day of the first month in which the Class 26 Employee meets the definition of "Part-Time Employee";
- The last day of the month in which the Class 26 Employee meets the definition of "employee" under the Taft-Hartley Act and does not, or has exhausted his right to, make Self-Payments;
- The last day of the month in which the Class 26 Employee's employment terminates, and the Class 26 Employee does not, or has exhausted his right to, make Self-Payments;
- The date the Employee becomes entitled to Benefits as an Early Retiree, Normal Retiree, or a Totally and Permanently Disabled Employee;
- The date the Class 26 Employee enters active military service;
- The date the Class 26 Employee dies;
- The date the Plan is terminated; or
- Such other event or occurrence set forth in the Plan that results in the Class 26 Employee's termination of eligibility.

In the event of a Class 26 Employee's death, Benefits for Eligible Dependents of the a Class 26 Employee shall terminate at the end of the calendar month in which the a Class 26 Employee dies. Otherwise, benefits for Eligible Dependents shall terminate when the a Class 26 Employee's eligibility terminates in accordance with this section

In addition to the events above, a Class 26 Employee will cease to be eligible for benefits under the Plan if the Employer fails to pay required contributions to the Plan or fails to follow the terms and conditions of the Participation Agreement.

**Eligibility for Early Retirees**

*Initial Eligibility:*
Early Retirement is available under either the Age 60 classification or the Rule of 85 as explained below. In either case, an Early Retiree must continue to make self-payments in the amount and at the time specified by the Board of Trustees.

To secure eligibility and obtain coverage, the Active or Class 26 Employee must apply to the Fund Office for Early Retirement by the 60th day after the last month in which the Active Employee was eligible to receive Benefits under the Plan. Failure to apply in a timely manner (e.g. within the 60-day limitation period) will result in the individual forever waiving any opportunity to become eligible for Early Retiree Benefits.

Employees become eligible for Benefits as an Early Retiree when they have satisfied the criteria for either Age 60 Early Retirement or "Rule of 85" Early Retirement as set forth below.

*Age 60 Early Retirement:*
An Active Employee may qualify for Age Early Retirement with all of the following:

- Attainment of 60 years of age;
- Participation in the Plan as a Covered Employee for a total of 120 months;
- Participation in the Plan as a Covered Employee for total of 60 continuous months immediately prior to retirement eligibility; and
- No longer eligible under the Plan as an Active Employee, Class 26 Employee, or an Apprentice.

*"Rule of 85" Early Retirement:*

An Active Employee may qualify for Rule of 85 Early Retirement by meeting all of the following:

- Attainment of 55 years of age;
- The sum of the Active Employee's age and the number of Plan Years during which he or she was paid any cash remuneration by an Employer who was making contributions to the Plan as a signatory employer equals or exceeds 85. The Active Employee or Class 26 Employee applying for Early Retiree eligibility based on the Rule of 85 may be required to furnish evidence satisfactory to the Board of Trustees to substantiate his or her claimed number of service credits; and
- Cessation of eligibility as an Active Employee, Apprentice, or Class 26 Employee.

*Continuous and Uninterrupted Service:*
For the purposes of Early Retirement, service will be considered continuous and without interruption if an Active Employee is employed

- As an electrical inspector for a governmental authority that is not obligated to contribute to the Plan and is within the geographical jurisdiction of I.B.E.W. Local Union No. 8; or
- As an electrical instructor for an educational institution that is not obligated to contribute to the Plan and is within the geographical jurisdiction of I.B.E.W. Local Union.

Further, for the purposes of establishing eligibility for Early Retiree Benefits, an Active Employee's service will be considered continuous and without interruption if the Active Employee, upon experiencing a loss of coverage under the Plan as a result of failing to satisfy the Plan's eligibility rules, re-establishes eligibility in the Plan within 12 months after initially becoming ineligible under the Plan.

*Termination of Eligibility*:
Eligibility for Benefits as an Early Retiree terminates as of the earlier of the following:

- 12:00 midnight on the last calendar day of the month in which the Early Retiree reaches age 65);
- The death of the Early Retiree; or
- The end of the month following the Early Retiree's failure to make the required self-payments.

Eligibility will also terminate at 12:00 midnight of the day on which an Early Retiree engages in any Unacceptable Work.

*Returning to Active Employment:*
An Early Retiree who returns to work may attain eligibility as:

- An Active Employee by returning and working 300 hours in Covered Employment over the course of 3 consecutive Work Months; or
- A Class 26 Employee by meeting the eligibility requirements set forth above.

Upon termination of his Active Employee or Class 26 Employee eligibility (due to reduction in hours worked or termination of employment), his eligibility as an Early Retiree will immediately be restored; or if he or she has attained 65 years of age as of the date thereof, he or she will immediately attain eligibility as a Normal Retiree. In the event that an Early Retiree returns to work but does not attain eligibility as an Active Employee or as a Class 25 Employee as provided in this paragraph, his Early Retiree eligibility will continue uninterrupted.

*Commencement and Termination of Eligible Dependents Eligibility:*
Eligible Dependents of an Early Retiree are entitled to Benefits as soon as the Early Retiree becomes eligible for Benefits. In the event of the Early Retiree's death, benefits for Eligible Dependents of Early Retirees shall terminate at the end of the calendar month in which the death of the Early Retiree occurs. Otherwise, benefits for Eligible Dependents shall terminate when the Early Retiree's eligibility terminates.

**Eligibility for Normal Retirees**

*Initial Eligibility:*
- An Active Employee become eligible for Benefits as a Normal Retiree once he or she has:
- Attained 65 years of age;
- Participated in the Plan as an Active Employee for a total of one hundred and 20 months;
- Participated in the Plan as Eligible Employees for a total of 36 months immediately prior to retirement eligibility;
- Ceased to be eligible for Benefits as an Active Employee, Class 26 Employee, Indentured Apprentice, or an Early Retiree under the Plan;
- Attained eligibility and has enrolled in both Medicare Part A & B; and
- Meets the other requirements of this Section.

*Continuous and Uninterrupted Service:*
An Active Employee's service will be considered continuous and without interruption if he or she is employed:

- As an electrical inspector for a governmental authority that is not obligated to contribute to the Plan and is within the geographical jurisdiction of I.B.E.W. Local Union No. 8; or
- As an electrical instructor for an educational institution that is not obligated to contribute to the Plan and is within the geographical jurisdiction of I.B.E.W. Local Union.

Further, for the purposes of establishing eligibility for Normal Retiree Benefits, an Active Employee's service will be considered continuous and without interruption if the Active Employee, upon experiencing a loss of coverage under the Plan as a result of failing to satisfy the Plan's eligibility rules, re-establishes eligibility in the Plan within 12 months after initially becoming ineligible under the Plan.

To secure eligibility and obtain coverage, the Active or Class 26 Employee must apply to the Fund Office for Normal Retirement by the 60$^{th}$ day after the last month in which he or she was

eligible for benefits under the Plan. Failure to apply in a timely manner (e.g. within the sixty-day limitation period) will result in the individual forever waiving any opportunity to become eligible for Normal Retiree Benefits.

*Termination of Eligibility for Normal Retiree:*
Eligibility for Benefits as a Normal Retiree terminates as of the earlier of the following:

- The death of the Normal Retiree; or
- The end of the month following the Normal Retiree's failure to make the required self-payments.

Eligibility will also terminate at 12:00 midnight of the day on which a Normal Retiree engages in any Unacceptable Work.

*Returning to Active Employment:*
A Normal Retiree who returns to work may become eligible for benefits as:

- An Active Employee by working 300 hours in Covered Employment over the course of 3 consecutive Work Months; or
- A Class 26 Employee by meeting the eligibility requirements set forth above

Upon termination of his Active Employee or Class 26 Employee eligibility (due to reduction in hours worked or termination of employment), the Active or Class 26 Employee will immediately return to Normal Retiree status. If a Normal Retiree returns to work but does not qualify as an Active Employee or a Class 26 Employee (e.g., not enough hours worked), his or her Normal Retiree eligibility will continue uninterrupted.

*Commencement and Termination of Eligible Dependent Eligibility:*
Eligible Dependents of a Normal Retiree are eligible for Benefits as soon as the Normal Retiree becomes eligible for Benefits. In the event of the death of the Normal Retiree, Benefits for Eligible Dependents of the Normal Retiree shall terminate at the end of the calendar month in which the death of the Normal Retiree occurs. Otherwise, benefits for Eligible Dependents shall terminate when the Normal Retiree's eligibility terminates.

**Eligibility for Totally and Permanently Disabled Employees**

A Total and Permanent Disability is a medical condition that:

- Results in the Active Employee being unable to engage in, and regularly perform, the duties of his occupation as an electrician. In the case of a Class 26 Employee, the medical condition must prevent the Class 26 Employee from engaging in and regularly performing the duties of his occupation immediately before the injury or illness; or
- Endangers the Active or Class 26 Employee's life to engage in, and regularly perform, the duties of his occupation as determined in accordance with a competent medical opinion.

A disability is considered permanent if it is expected to continue for the remainder of the Active Employee's natural life.

*Initial Eligibility:*
A Totally and Permanently Disabled Employee and his Eligible Dependents are eligible for Benefits, if immediately prior to the date that the Total and Permanent Disability was incurred, the Active Employee satisfies the following 3 conditions:

- The Active Employee maintained continuous Active Employee status for 24 months before the date the illness or injury occurred;
- The Active Employee has exhausted his or her short-term disability benefits (26 weeks); and
- Prior to the expiration of the maximum number of allowed self-payments, such Employee submits an application for Total and Permanent Disabled Employee status with proof of a Social Security Award of Total and Permanent Disability, proof of approval of a Total and Permanent Disability benefit from a qualified (Internal Revenue Code §401, et seq.) International Brotherhood of Electrical Workers related pension plan or a corporate retirement plan, and/or proof of a Total and Permanent Disability as determined by the Board of Trustees. Failure to submit the required proof will result in the loss of eligibility.

Upon presentation of proof of disability and the Board of Trustees' approval of Total and Permanent Disability, the Employee will be allowed to continue to make self-payments at the same rate paid by an Early Retiree until a Medicare award is granted. Upon the presentation of proof of a Medicare award, the Totally and Permanently Disabled Employee eligibility status will be changed to Normal Retiree and continued eligibility will be subject to the Normal Retiree provisions of the Plan. There is a 24-month waiting period before Medicare will cover health expenses in case of Total and Permanent Disability. Therefore, do not wait to file for Social Security and Medicare benefits.

*Continuing Eligibility:*
Once approved by the Trustees, the Totally and Permanently Disabled Employee will be allowed to continue to participate in the Plan by making self-payments at 25% of the Active Employee Self-Payment rate until a Medicare award is granted. Eligible Dependents will also be covered under the applicable Medical benefits plan. Once the Medicare award is granted, the Active Employee's status will be changed to a Normal Retiree and the Normal Retirees rules will apply. Totally and Permanently Disabled Employees and Eligible Dependents are eligible for Plan R until a Medicare award is granted.

*Termination of Eligible Dependent Eligibility:*
In the event of the Totally and Permanently Disabled Employees death, Benefits for Eligible Dependents of the Totally and Permanently Disabled Employee shall terminate at the end of the calendar month in which the death of the Totally and Permanently Disabled Employee occurs. Otherwise, benefits for Eligible Dependents shall terminate when the Totally and Permanently Disabled Employee's eligibility terminates.

**Eligibility for Surviving Spouses and Surviving Eligible Dependents**

*Initial Eligibility:*
Surviving spouses and/or surviving Eligible Dependents that meet the qualifications listed below are eligible for Benefits under the Plan if the deceased Eligible Employee of the surviving spouse and/or surviving Eligible Dependent had a total of at least 36 months of continuous participation in the Plan immediately prior to the month in which the deceased Eligible Employee's eligibility terminated. Coverage for surviving Spouses and surviving Eligible Dependents is available on the following terms:

- The surviving Spouse and/or surviving Eligible Dependent must apply for coverage to the Fund Office within 60 days of the death of the Eligible Employee. A surviving Spouse and/or surviving Eligible Dependent will waive the right to receive benefits under this Plan if the 60 day deadline is ignored.
- If the deceased Eligible Employee had more than 36 months, but less than 120 months of participation in the Plan, the surviving spouse and/or surviving Eligible Dependents will be eligible for benefits under this Plan for the number of months of participation accumulated by the Eligible Employee prior to his or her death.
- If the deceased Eligible Employee had 120 or more months of participation in the Plan, the surviving spouse and/or surviving Eligible Dependents will continue to be eligible for benefits under the Plan until one of the events specified in the Section "Termination of Eligibility" below occurs.

Additionally, a surviving spouse who is covered by another group health plan may elect a limited schedule of benefits with no self-payment due (more fully described in "Alternative Coverage" on page 18). This limited schedule of benefits includes reimbursement for certain uncovered medical expenses. If a surviving spouse elects Alternative Coverage and later loses eligibility under the other group health plan, or suffers a material adverse change in the nature or cost of coverage provided under the other group health plan, he or she may cancel Alternative Benefits and instead elect to receive full benefits under this Plan. The maximum period of eligibility for full benefits is not reduced by any Alternative Coverage period.

*Termination of Eligibility for Surviving Spouses and Surviving Eligible Dependents:*

For Surviving Spouses, eligibility for Benefits will terminate at the end of the calendar month when any of the following events occur:

- The death of the surviving spouse;
- Except for Alternative Coverage, the surviving spouse becomes eligible for coverage under another group health plan; or
- The discontinuance of all coverage for surviving spouses under the Plan.

For Surviving Eligible Dependents, eligibility for Benefits will terminate at the end of the calendar month when any of the following events occur:

- The death of the surviving Eligible Dependent;
- The surviving Eligible Dependent becomes eligible for Medicare, whether or not enrolled or applied for;
- The surviving Eligible Dependent becomes eligible for coverage under another group health plan;
- The surviving Eligible Dependent no longer qualifies as an Eligible Dependent (e.g., attainment of age 26);

- The surviving Eligible Dependent becomes eligible for benefits as an Active Employee or a Class 26 Employee under the Plan; or

- The discontinuance of all coverage for surviving Eligible Dependents under the Plan.

**Self-Payments**

If an Participant loses eligibility for reasons other than death, the termination of the Plan, or eligibility as a Normal Retiree, Early Retiree, or Totally and Permanently Disabled Employee, he or she may, in lieu of electing Continuation Coverage as set forth below, make Self-Payments to continue participation in the Plan, subject to and in accordance with the provisions of this section. These rules and procedures governing Self-Payments are established by the Board of Trustees. However, in no event shall Self-Payments exceed 20 payments in any 24 month period.

Self-payments must be postmarked or received by the Fund Office by the first day of the month of coverage. There is a 10-day grace period from the first day of the month; if payment is received on or before the 10th day of the month, it will not incur a late fee. Late payments will be accepted from the 11th day of the month through the last day of the month but will incur a $10 per day late fee. Such late fees will be added to the Self-Payment amount and are considered part of that month's Self-Payment. Partial Self-Payments will not be accepted. In any month a Self-Payment is late, claim payments will be pended until the payment is received or coverage is terminated for non-payment. Termination of coverage will be retroactive to the first day of the month for which the Self-Payment was not made.

The provisions below describe the length of time Self-Payments can be made for each Employee classification. Note, no hours are credited when Self-Payments are made. Once Self-Payments are required to maintain eligibility, coverage under the Plan is provided on a month-to-month basis.

*Inside Apprentices, Residential Trainees [Per. 3-8] & Teledata Apprentices [Div. 3–6]); Cable Pullers:*
Upon the occurrence of an event that would otherwise cause the termination of eligibility, Apprentices may make Self-Payments for one month to maintain eligibility.

*Active Employees (Journeymen):*
An Active Employee, in danger of losing eligibility because he or she has not worked the required number of hours of Covered Employment, may maintain eligibility by making Self-Payments.

Active Employees may make Self-Payments for a maximum of 20 months within any 24 month period in order to maintain eligibility in the Plan.

*Self-Payment Contribution Formula:*
The Self-Payment Contribution Formula establishes the monthly amount an Active Employee must pay in order to retain eligibility under the Plan. The Formula is the total number of hours worked during the 3 month test period related to the month of eligibility divided by 300, where 300 represents the number of hours needed to maintain eligibility. The percentage is then multiplied by the full monthly self-payment amount. The resulting product is then subtracted from the monthly self-pay amount. This calculation yields the self-payment the Active Employee must pay to continue coverage. See the example below.

**Example:** Hector works 120 hours in June, 110 hours in July, and 12 hours in August for a total of 242 hours during the 3-month test period. This test period determines eligibility for November.

- Step 1 – 242 hours divided by 300 = 80.667%
- Step 2 – 80.67% times the $1,450 self-pay rate (as of 1/1/2020) = $1,169.67
- Step 3 – $1,450 less $1,169.67 = $280.33
- $280.33 is the monthly self-payment for Hector to retain eligibility for November.

The required monthly contribution will never be greater than the full monthly self-payment amount.

The monthly self-pay amount is generally set by the Board of Trustees on an annual basis. The amount of the required self-payment and any applicable waiver as explained below shall be established in accordance with the Rules and Regulations promulgated by the Board of Trustees and are subject to modification. Contact the Fund Office for the current amount.

*Short-Term Disability Self-Payments:*
An Active Employee that is on a short-term disability claim can continue benefit eligibility on a zero pay basis. If an Active Employee is no longer eligible for benefits under a short-term disability claim but is still off work due to their disability, they can continue eligibility on a self-pay waiver basis. The hours earned in the test period prior to their disability will be reactivated when they come off their short-term disability claim and considered in determining their self-pay amount. Once an Active Employee is deemed able to work, normal eligibility and self-pay rules apply.

*Self-Payment Waiver:*
An Active Employee may accrue up to 15 Self-Payment Waivers in his or her self-pay waiver bank. Self-Payment Waivers allow the Active Employee to make reduced self-payments to continue eligibility. An Active Employee accrues a Self-Payment Waiver in each month in which he or she does not use a waiver or otherwise make a Self-Payment.

If an Active Employee loses employment through no fault of his own (e.g., laid-off) and is on the Out of Work List, he or she is eligible to use a Self-Payment Waiver. The Waiver rate is capped at 23% of the full monthly self-pay rate. Self-Payment Waivers may be used for up to 15 months in any 24-month period. Active Employees that exhaust their self-pay waiver eligibility can continue coverage by paying the full self-pay amount for up to a total of 20 months (e.g. an additional 5 months of self-payments, if the Active Employee used 15 waivers). Self-Payment Waivers are illustrated in the following examples:

**Example:** Laura works 110 hours in September, 10 hours in October, and zero in November for a total of 120 hours during the 3-month test period. This test period determines eligibility for February of the following year. In November, Laura was laid off-through no fault of her own and signs the Out of Work List and is therefore eligible for the waiver.

- Step 1 – 120 hours divided by 300 = 40%
- Step 2 – 40% times the $333.50 self-pay waiver rate (as of 1/1/2020) = $133.40
- Step 3 – $333.50 less $133.40 = $200.10
- Since Laura is eligible for the waiver, $200.10 is the monthly self-payment for Laura to retain eligibility for February.

**Example:** Mike was laid off through no fault of his own in March and signed the Out-of-Work List the same month. For October eligibility, Mike will have zero hours (May/June/July Work Hours).

- Step 1 – 0 hours divided by 300 = 0%
- Step 2 – 0% times the $333.50 self-pay waiver rate = $0
- Step 3 – $333.50 less $0 = $333.50
- Since Mike is eligible for the waiver, $333.50 is the monthly self-payment for Mike to retain eligibility for October.

Monthly self-pay amounts less than $30 are waived.

An Active Employee is not eligible for the Waiver if he or she is fired or retires. An Active Employee is eligible for the Waiver if he or she voluntarily resigns (quits), or "rolls the book" as long as the month in which the Active Employee quit or rolled the book is not included in their test period.

**Example:** Monica worked 125 hours in January, 125 hours in February, 40 hours in March and 10 hours in April. She quit in April. For the January/February/March test period Monica worked 290 hours. Since the month in which she quit (April) is not included in the test period, she would be eligible for the waiver for June eligibility.

- Step 1 – 290 hours divided by 300 = 97%
- Step 2 – 97% times the $333.50 self-pay waiver rate = $323.50
- Step 3 – $333.50 minus $323.50 equals $10.00

Self-pay amounts under $30 are waived, therefore, Monica's self-pay amount for June is $0.

**Example:** Monica, from the previous example, is not eligible for the self-pay waiver in July since the month in which she quit (April) is included in his or her test period (February/March/April). Monica worked 175 hours in the test period.

- Step 1 – 175 hours divided by 300 = 58%
- Step 2 – $1,450 full self-pay amount multiplied by 58% equals $841.00
- Step 3 – $1,450 minus $841.00 equals $609.00. Therefore, Monica's self-pay amount for July is $609.

Monica will not become eligible for the waiver again until she reinstates her eligibility.

*Class 26 Employees:*
Upon the occurrence of an event that would otherwise cause the termination of eligibility, a Class 26 Employee may maintain eligibility by making self-payments in accordance with the terms and provisions of rules and regulations promulgated by the Board of Trustees from time to time.

*Totally and Permanently Disabled Employees:*
Upon the occurrence of an event that would otherwise cause the termination of eligibility, a Totally and Permanently Disabled Employee may maintain eligibility by making self-payments in the amount of 25%, as of November 1, 2019, of the full monthly Self-Payment amount and at the time specified by the Board of Trustees.

*Base Only Benefits:*
Upon the occurrence of an event that would otherwise cause the termination of an individual's eligibility for Base Only Benefits, except for death or the termination of the Plan, an individual who is eligible for Base Only Benefits may maintain eligibility by making self-payments in accordance with the terms and provisions of rules and regulations promulgated by the Board of Trustees from time to time. However, in no event shall such self-payments exceed 20 payments in any 24 month period.

Self-payments must be postmarked or received by the Fund Office by the first day of the month of coverage. There is a 10-day grace period from the first day of the month; if payment is received on or before the 10th day of the month, it will not incur a late fee. Late payments will be accepted from the 11th day of the month through the last day of the month but will incur a $10 per day late fee. Such late fees will be added to the Self-Payment amount and are considered part of that month's Self-Payment. Partial Self-Payments will not be accepted. In any month a Self-Payment is late, claim payments will be pended until the payment is received or coverage is terminated for non-payment. Termination of coverage will be retroactive to the first day of the month for which the Self-Payment was not made.

*Early Retirees:*
Eligibility for Benefits as an Early Retiree is conditioned on making self-payments to the Plan at such times and in such amounts as established by the Board of Trustees. Early Retirees are eligible to make Self-Payments at a discounted rate from the standard self-pay rate based on their age and years of service, as shown in this table:

| | **Early Retiree** | |
|---|---|---|
| **Years of Service** | **Minimum Age** | **% Paid by Early Retiree*** |
| **25 or More** (last 5 continuous) | 62, 63 or 64 | 25% |
| **Rule of 85** (last 5 continuous) | 55 | 50% |
| **24** (last 5 continuous) | 60 | 50% |
| **23** (last 6 continuous) | 60 | 50% |
| **22** (last 7 continuous) | 60 | 50% |
| **21** (last 8 continuous) | 60 | 50% |
| **20** (last 9 continuous) | 60 | 50% |
| **15 - 19** (last 10 continuous) | 60 | 50% |
| **14** (last 10 continuous) | 60 | 60% |
| **13** (last 10 continuous) | 60 | 70% |
| **12** (last 10 continuous) | 60 | 80% |
| **11** (last 10 continuous) | 60 | 90% |
| **10** (last 10 continuous) | 60 | 100% |
| ***** Percent of self-pay amount due per month; self-payment amount is determined annually by the Board of Trustees. Call the Fund Office for an updated self-pay amount. | | |

*Normal Retirees:*
Eligibility for Benefits as a Normal Retiree is conditioned on making self-payments to the Plan at such times and in such amounts as established by the Board of Trustees from time to time. As of January 1, 2020, the Self-Payment Rate for Normal Retirees who are at least 65 years old and have at least 10 years of service is 8% of the full Self-Payment Rate for the retiree only or 16% of the full Self-Payment Rate for retiree and Spouse.

**Alternative Group Health Coverage/Opt-Out**

An Active Employee, Early Retiree, Normal Retiree, or Surviving Spouse who is otherwise eligible for Benefits but who has coverage available from another group health plan can opt to waive participation in the Plan ("Opt Out"), receive other benefits from this Plan in lieu of full coverage, and to re-enroll for coverage under this Plan upon the loss of the other coverage (collectively, "Opt-Out Benefits"). For purposes of this Section, the term "group health plan" shall mean a group health plan as defined in ERISA § 733(a), i.e., an employee welfare benefit plan to the extent that the plan provides medical care, which shall mean any and all amounts paid for (a) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (b) amounts paid for transportation primarily for and essential to medical care referred in (a); and (c) amounts paid to provide insurance coverage medical care referred to in (a) and (b), including items and services paid for medical care to Employees or their Eligible Dependents directly or through insurance, reimbursement, or otherwise.

Active Employees (Class 1 and 26):

Any Active Employee that is maintaining eligibility as an Active Employee in the Plan by making Self-Payments may elect to receive coverage from another group health plan instead of making Self-Payments to continue eligibility in the Plan. That Active Employee may re-enroll in the Plan under one of the following conditions:

- Immediately upon loss of eligibility for coverage through the other group health plan as a result of a termination of employment (or reduction in hours of employment) of the person through whom the coverage is provided or upon suffering a material adverse change in the nature of the cost of coverage provided under such other group health plan; or
- At any other time provided that the Active Employee pays the applicable Self-Payment due and has not "Rolled the Book" within the previous 12 months prior to the request to re-enter. For these purposes, the term "Rolling the Book" shall have the same meaning as used by the Union to describe the refusal or inability of an Active Employee to perform work. If an Active Employee has Rolled the Book within the 12 month time period preceding the request to re-enter the Plan, such Active Employee shall not be permitted to re-enroll in the Plan and may only re-establish eligibility through Hours Worked as provided herein.

Further, an Active Employee currently receiving Opt-Out Benefits under this subsection shall become ineligible for said Opt-Out Benefits in the event the Active Employee Rolls the Book.

If an Active Employee elects to receive health benefits under another group health plan, then on the condition that the Active Employee re-enrolls in the Plan, the period of time the Active Employee receives coverage under another group health plan shall count as eligibility under the Plan for purposes of determining eligibility for Benefits that are conditioned on continuous eligibility under the Plan; provided always that the maximum number of months that will be considered for purposes of continued eligibility under the Plan shall not exceed 20 months.

The months that an Active Employee receives coverage under another group health plan pursuant to this section shall not count towards the limitation for Self-Payments for continued eligibility under the Plan; instead the accumulation of time for purposes of calculating consecutive months will be tolled and shall resume upon the Active Employee's re-enrollment in the Plan.

Early and Normal Retirees:
An Early or Normal Retiree may elect Opt-Out Benefits. An Early or Normal Retiree may elect to receive Opt-Out Benefits at any time after becoming eligible for Benefits as an Early or Normal Retiree by filing an election with the Fund Office. Eligibility for Opt-Out Benefits is conditioned on the Retiree maintaining eligibility at a reduced rate of self-contributions. An Early or Normal Retiree who has elected to receive Opt-Out Benefits may elect to return to eligibility for full Benefits only upon the occurrence of a qualifying life changing event, which means:

- The birth or adoption of a Child;
- Termination of employment of the Early Retiree or Spouse; or
- Significant material change in other health insurance coverage covering the Early Retiree.

Eligible Dependents of an Early Retiree who elects to receive Opt- Out Benefits shall only be eligible for Opt-Out Benefits as well.

An Early or Normal Retiree who elects to receive coverage from another group health plan in accordance with the provisions of this Section is eligible to receive reimbursement of up to $5,000 per calendar year for the cost associated with any alternative coverage plan premiums or medical expenses incurred by the Early or Normal Retiree or their Eligible Dependents for medical care not otherwise covered by the alternative coverage.

Surviving Spouse:
A Surviving Spouse who is eligible for Surviving Spouse Benefits as provided herein and who is covered by another group health plan may elect Opt-Out Benefits in order to receive reimbursements for expenses of medical care (as defined in Code § 213(d)) not otherwise covered under other insurance or another health plan of up to $300 per calendar year if Alternative Coverage has been elected solely for the Surviving Spouse, or up to $600 per calendar year if Alternative Coverage has been elected for the Surviving Spouse and all Surviving Eligible Dependents. Surviving Eligible Dependents do not have an independent right to elect Opt-Out Benefits.

If a Surviving Spouse who has elected Alternative Coverage (i) loses eligibility for coverage under the other group health plan as a result of a termination of employment (or a reduction in hours of covered employment), or (ii) suffers a material adverse change in the nature or cost of the other group health plan, the Surviving Spouse may, within 60 days after the event resulting in the loss or change in such group health plan coverage, and in accordance with procedures established by the Board of Trustees, cancel the Alternative Coverage and elect to obtain Benefits as a Surviving Spouse and/or Surviving Eligible Dependent under the Plan effective on the first day of the month following the election of Surviving Spouse or Surviving Eligible Dependent Benefits. The maximum period of eligibility for Benefits as a Surviving Spouse and/or Surviving Eligible Dependent will not be reduced by any period during which the Surviving Spouse and/or Surviving Eligible Dependent receives Alternative Coverage.

**Special Enrollment**
If you were eligible to enroll under the Plan and declined coverage because of other coverage, and you or your dependent lose the other coverage, you and your Eligible Dependent(s) will be permitted to enroll during a special enrollment period if loss of the other coverage was due to:

- termination of employment;

- a reduction in hours of employment;
- termination of the other coverage;
- termination of employer contributions toward coverage;
- the exhaustion of COBRA continuation coverage;
- the exhaustion of applicable lifetime benefits under the coverage;
- an individual ceases to be a dependent under the plan;
- the plan terminates a benefit package option;
- if your coverage is provided through a Health Maintenance Organization (HMO) or other arrangement, and you no longer live or work in the HMO's or other arrangement's service area (and there is no other coverage available under the plan);
- the plan no longer offers coverage to a class of similarly situated individuals that includes you (e.g., the plan terminates coverage for all part-time employees);
- layoff;
- the death of or divorce from your spouse; or
- loss of eligibility for Medicaid or a State child health insurance plan (a "CHIP" plan).

Enrollment must be supported by written documentation of the termination of the other coverage (including the effective date of the termination). Notice of intent to enroll must be provided to the Fund Office within 31 days of the event (60 days for loss of eligibility for Medicaid or CHIP) with coverage to be effective on the date the other coverage terminated.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Eligible Dependents provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Finally, you are entitled to special enrollment if you, your spouse or other Dependent becomes eligible for state CHIP assistance or coverage under Medicaid and request coverage under the Plan within 60 days after you or your Dependent are determined to be eligible for such assistance.

**Employees Serving in the Armed Forces**
Eligible Employees covered by the Plan have a right to choose Continuation Coverage if coverage is lost as the result of an Eligible Employee's service in the Uniformed Services.

The Continuation Coverage shall consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the Plan to similarly situated beneficiaries under the Plan, who have not lost coverage as the result of service in the Uniformed Services. If coverage under the Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all individuals who are beneficiaries under the Plan.

Continuation Coverage shall be available up to the maximum of:

- The 24-month period beginning on the date on which the Eligible Employee's absence begins as a result of service in the Uniformed Services; or
- The day after the date on which the Eligible Employee fails to apply for or return to a position of employment, as determined in accordance with 38 U.S.C. § 4301 et. seq.

Any Participant that chooses to receive continuation coverage under this section shall pay to the Plan a monthly payment equal to the amount in effect from time to time for Eligible Employees electing continuation of their group health coverage under the Plan pursuant to the provisions of this section of the Plan.

**Qualified Medical Child Support Orders (QMCSO's)**
A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a child or children with health insurance. If the Plan Administrator receives a QMCSO, the Plan Administrator will contact the Participant concerning Plan procedures for such an order. The Plan Administrator will review the order for compliance with the law so it can be deemed qualified. Should the order be defective, the Plan Administrator reserves the right to request changes. Contact the Plan Administrator for a complete copy of the Plan's QMCSO procedures.

## II. RESCISSION OF COVERAGE

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf) perform an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission, or intentional misrepresentation by your employer.

You will be provided with 30 calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

## III. COORDINATION OF BENEFITS

**Coordination of Benefits**
Coordination of Benefits is the procedure used to pay health care expenses when an Eligible Employee or his or her Eligible Dependent(s) are covered by more than one health care plan (including medical, dental, vision, and prescription drug benefits). The Plan follows rules established by NAIC Coordination of Benefits Model Regulation to decide which health care plan pays first and how much the other health care plan must pay.

This Plan will coordinate benefits with any other group insurance plan, no-fault automobile insurance as required by law, HMO, or governmental program. In such an event, the primary plan will pay its benefits in full, with the secondary plan paying either its benefits in full or at a reduced amount, such that the total paid by both plans will not exceed 100% of the allowable expense.

You must submit all bills first to the primary health care plan. When this Plan is primary, benefits are determined before those of the other plan(s) and without regard to the benefits provided by that other plan(s). However, when this Plan is secondary, benefits are determined after those of the other plan(s). Therefore, benefits under this Plan may be reduced because of the benefits provided by the other plan(s).

**Tip:** Spouses with access to other health coverage must enroll in that coverage if the cost is $120 or less per month; that other coverage will be primary for the Spouse. Children can remain in the Plan; the other coverage is mandatory for the Spouse only. A brochure explaining this rule is available at the Fund Office or on our website at www.electricalfunds.org.

The Plan pays for health care only when you follow the Plan's rules and procedures. If the Plan's rules conflict with those of another health care plan, it may be impossible to receive benefits from both health care plans, and you will be forced to choose which health care plan to use.

**Order of Determination**
This Plan determines its order of benefits using the following rules when applicable:

- A plan that does not coordinate with other plans is always the primary plan.
- The plan which covers the person as an employee, member, or subscriber (other than as a dependent) is the primary plan, and the plan that covers the person as a dependent is the secondary plan.
- If this Plan and another plan cover the same Child as a Dependent, the plan of the parent whose birthday falls earlier in the year is the primary plan. The plan of the parent whose birthday is later in the year is the secondary plan.
- If this Plan and another plan cover the same Child as a Dependent of divorced or separated parents, the parent who has custody of the Child is the primary plan. The plan of the other, non-custodial, parent is the secondary plan. However, if the specific terms of a court decree provide otherwise, benefits will be determined in accordance with the court decree once the Participant has provided notice.
- The primary plan is the plan that covers a person as an employee that is neither laid off nor retired (or as that Employee's Dependent). The secondary plan is the plan that covers that person as a laid off or retired employee (or as that Employee's Dependent). However, if the other plan does not have this rule and the plans do not agree on the order of benefits, this rule does not apply.
- If none of the above rules apply, the plan which covered an employee, member, or subscriber longer is considered the primary plan. The plan which covered that person for a shorter time is considered secondary.

When another plan contains an "always secondary" provision, and that plan would be required to pay primary benefits under the rules stated above, or contains a provision capping its benefits for an eligible individual or his dependent having the effect of shifting primary coverage liability to this Plan in a manner designed to avoid the usual operation of the NAIC's and this Plan's coordination of benefits rules, this Plan will estimate what the primary benefits would be and will pay secondary benefits before the other plan's benefits are paid.

**Coordination with Medicare**
Coordination with Medicare, TRICARE, or any other similar Federal or state program is determined under the applicable Federal and state regulations. <u>All Participants must sign up for Medicare Parts A and B as soon as they are eligible and entitled to do so, whether by reason of age or disability.</u> You must notify us when you or an Eligible Dependent becomes eligible to enroll in Medicare.

*IMPORTANT:* If you are eligible for Medicare, the Plan will pay benefits only up to the amount that would be paid under the above rules, whether or not you have applied for Medicare benefits. Because your Plan Benefits may be affected by Medicare, you may want to contact your Social Security office for information about Medicare. This should be done before your or your spouse's 65th birthday, or if you or one of your dependents become Disabled.

**Coordination with Health Maintenance Organizations**
If a spouse is entitled to coverage under another group health insurance plan through that spouse's employer or otherwise, and is entitled to and does choose coverage under a health maintenance organization ("HMO") as an alternative method, that HMO will be the primary plan and the Plan will be secondary with respect to the spouse. This rule applies whether or not the spouse actually uses the HMO in a particular instance. If the spouse's HMO would normally be the primary insurer for any dependent children, then the HMO will be the primary plan and this Plan will be secondary.

**Automobile Insurance Coverage**
If an Eligible Employee or his or her Dependents are covered by an Automobile Insurance Coverage policy and that insurance plan is required to provide medical coverage under its policy, the Plan will always be secondary to the Automobile Insurance Coverage policy.

**Coordination Disputes**
If you believe that the Plan has not paid a Coordination of Benefits claim properly, you should attempt to resolve the problem by contacting the Fund Office.

**Provision Enforcement**
The Plan will coordinate benefits to the extent that the Plan is informed by you or some other person or organization of your coverage under any other health care plan. The Plan is not required to determine if and to what extent you are covered under any other health care plan.

In order to apply and enforce this provision or any provision of similar purpose of any other health care plan, it is agreed that:

- Any person claiming benefits described in Plan will furnish the Plan with any information it needs; and
- The Plan may, without the consent of or notice to any person, release to or obtain from any source any necessary information.

**Facility of Payment**
If payment is made under any other health care plan which the Plan should have made under this provision, then the Plan has the right to pay whoever paid under the other health care plan; the Plan will determine the necessary amount under this provision. Amounts so paid are benefits under the Plan, and the Plan is discharged from liability to the extent of such amounts paid.

**Right of Recovery**
If the Plan pays more than this provision requires, it has the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure the Plan's right to recover the excess payment.

## IV. CONTINUATION OF COVERAGE

**Introduction**
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. You will receive an initial notice of your right to COBRA continuation coverage when you become initially eligible for coverage.

If you lose eligibility for Benefits due to low hours, you also can continue your Benefits for up to 20 months in any 24 month period by self-paying. Please see Section I, "Self-Payments," for more information or contact the Fund Office.

**What is COBRA Continuation Coverage?**
COBRA continuation coverage is a continuation of Plan coverage in effect the day before coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Eligible Employees, Spouses, and Eligible Dependents could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If COBRA continuation coverage is elected, coverage will continue as though loss of eligibility had not occurred. If any changes are made to the coverage for Active Employees, the coverage provided to individuals under this continuation provision will be changed similarly.

**Qualified Beneficiaries**
Eligible Employees become qualified beneficiaries when they lose coverage under the Plan because of one of the following qualifying events:

- Hour of employment are reduced, or
- Employment ends for any reason other than gross misconduct.

Spouses of Eligible Employees become a qualified beneficiaries when they lose coverage under the Plan because of one of the following qualifying events:

- The Eligible Employee dies;
- The Eligible Employee's hours of employment are reduced;
- The Eligible Employee's employment ends for any reason other than his or her gross misconduct;
- The Eligible Employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The Eligible Employee and Spouse become divorced or legally separated.

Eligible Dependents become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The Eligible Employee dies;
- The Eligible Employee's hours of employment are reduced;

- The Eligible Employee's employment ends for any reason other than his or her gross misconduct;
- The Eligible Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Eligible Dependent stops being eligible for coverage under the plan as an "Eligible Dependent.

**Qualifying Events and Duration of COBRA Continuation Coverage**
The length of the continuation coverage available depends on the nature of the qualifying event.

Coverage is available for up to 18 months to an Eligible Employee and his or her Spouse and/or Eligible Dependents if coverage is lost due to termination of employment for any reason except gross misconduct or reduction in work hours.

Coverage is available for up to 29 months to a Participant and his or her covered spouse and/or dependents in the event of a disability (as defined under the Social Security Act) that occurs on or within 60 days after a Participant's termination of employment or reduction in work hours. In other words, the original 18 month continuation coverage period is extended by 11 months if a disability occurs within 60 days after coverage is lost. The disabled individual must provide the Plan Administrator with notice of the disability within 60 days after the determination by the Social Security Administration and before the end of the original 18 month COBRA continuation coverage period. The disabled individual must also notify the Plan Administrator within 30 days if Social Security later determines that he or she is no longer disabled.

Coverage is available for up to 36 months to a covered dependent spouse and/or child if coverage is lost due to: (i) the Participant's death, (ii) a divorce or legal separation from the Participant, (iii) attainment of age or marriage, or (iv) due to the Participant becoming covered by Medicare as a result of a total disability or choosing Medicare in place of this Plan at age 65.

The duration of COBRA will be measured from the day of the qualifying event. The potential 18-29 or 36-months' duration will include any months that eligibility is extended via self-payments.

**When is COBRA Continuation Coverage Available?**
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Fund Office of the qualifying event.

**For the other qualifying events (divorce or legal separation, or an Eligible Dependent losing eligibility), the Eligible Employee, Spouse, or Eligible Dependent must notify the Plan Office within 60 days after the qualifying event occurs. Notice must be provided to the Administrative Manager at the address in the front of this booklet.**

**How is COBRA Continuation Coverage Provided?**
Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA

continuation coverage on behalf of their children. If continuation coverage is not chosen, health benefits will end.

Qualified beneficiaries have 60 days from the qualifying event, or if later, 60 days from the date the Plan Administrator provides notice regarding a qualified beneficiary's to elect COBRA continuation coverage. Each covered person is required to notify the Plan Administrator within 60 days of any qualifying event of which it would not otherwise be aware, such as divorce, legal separation, or loss of Eligible Dependent status by a dependent child. The covered person is also required to provide the Plan Administrator with all information needed to meet its obligation of providing notice and continuation coverage.

**Termination of COBRA Continuation Coverage**
The law provides that continuation coverage may be cut short for any of the following reasons:

- The date the maximum continuation period expires for the corresponding Qualifying Event;
- The date the Plan is terminated;
- The date the individual fails to make the required premium payments to continue coverage;
- The date the individual becomes covered under any other group health plan;
- The date the individual becomes covered by Medicare; or
- With respect to coverage in excess of 18 months by reason of disability, the end of the 1st month that begins after a final determination under the Social Security Act that the disabled individual is no longer disabled.

**Cost of COBRA Continuation Coverage**
The cost of COBRA continuation coverage is set by the Board of Trustees from time to time; generally, the cost for continuation coverage is equal to 102% of the Plan's average cost of benefits per covered person for the preceding year. However, a disabled individual may pay 150% of the Plan's cost after the first 18 months of continuation coverage. Payment of the initial monthly contribution is not required until the 45th day after the election; however, premiums are due retroactively to the date of the qualifying event. All subsequent payments for coverage are subject to a 30-day grace period.

## V. OPTIONS IF NO FURTHER COVERAGE IS AVAILABLE UNDER THE PLAN

There may be other coverage options for you and your family. You may buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can review your potential premiums, deductibles, and out-of-pocket costs before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan).

If you are losing coverage under the Plan, you should immediately consider:

- Any special enrollment right available to you under your spouse's health plan based on your loss of group health coverage (generally available for only 30 days after your loss of coverage under this Plan); and/or
- COBRA continuation coverage; and/or

- Enrolling in a health maintenance organization or HMO (health insuring corporation); and/or
- A health insurance exchange; and/or
- Enrolling in Medicare based on your age, a Total and Permanent Disability, or end-stage renal disease; and/or
- Medicaid; and/or
- Purchasing Supplementary Medicare Coverage.

You may lose valuable legal rights if you delay consideration.

## VI. SCHEDULE OF BENEFITS

This Schedule of Benefits is effective January 1, 2020, and updated from time to time. The Schedule for Active Benefits (Plan A), covering Inside Apprentices, Inside Journeymen, Residential Journeymen, Teledata Apprentice (Div. 3-6), Teledata Journeymen and Class 26 Employees, begins on page 30, and includes a brief description of benefits for the Totally & Permanently Disabled, Surviving Spouses and available Opt-Out Options.

The Schedule for Base-Only Benefits (Plan B), covering Residential Trainees (Per. 3-8), Teledata Apprentices (Div. 1-2), and Cable Pullers begins on page 39. The Schedule for Early Retirees (Plan R) begins on page 47; the Schedule for Normal Retirees (Plan M) begins on page 55.

These Schedules of Benefits are intended as an easy-to-read summary and provide only a general overview of benefits available under the Plan. Additional limitations and exclusions may apply, and are covered later in this booklet.

Claim payment amounts are based on Usual and Customary amounts established by the Plan and its Trustees in conjunction with their advisors and contracted service providers, less any applicable deductible, copayment and/or coinsurance. Charges will be considered payable in accordance with this schedule so long as they are medically necessary, prescribed by a physician, arise out of a non-occupational accident or sickness and do not exceed the reimbursement amount adopted by the Trustees. For a complete description of benefits please see the applicable sections of this Plan Document.

Participants seeking care from providers that do not accept, as full payment, the Usual and Customary amount established by the Plan may be liable for a Balance Bill amount over and above the deductible, copayment, and coinsurance maximums. A Balance Bill is the difference between gross billed charges and the FrontPath negotiated fee.

## Plan A Schedule of Benefits

*Please Note: for most Out-of-Network services listed in this schedule, Balance Bills, if any, are not covered*

| Benefit Item | In-Network | Out-of-Network |
|---|---|---|
| Lifetime Plan Maximum | None | |
| Participant Responsibility | Deductibles, copays, coinsurance and out-of-pocket maximums. If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable cost sharing including potential balance bill amounts except in certain circumstances Effective for any procedures with a date of service on or after January 1, 2016, the Toledo Electrical Welfare Fund will cover out-of-network physician, radiology, pathology, and anesthesiology services rendered at an in-network facility at the in-network rate. In other words, if you received these services at an in-network facility but were subjected to out-of-network charges, the Funds Office will reassess the claim and make an additional payment to the provider. Please review your Explanation of Benefits notices after receiving medical services to determine whether this has occurred and contact the Funds Office for additional claims review. | |
| Utilization Review<br>Prior Authorization Requirement | A penalty may apply if your provider fails to obtain prior authorization from the Plan's utilization review vendor for all inpatient (including maternity), inpatient physician, or any chiropractic, surgical, diagnostic, x-ray, therapy, durable medical equipment or intensive outpatient substance abuse services. Home health, home infusion services and hospice care are not covered without prior authorization. | |
| Preauthorization for Specialty Pharmaceuticals, Compound Prescriptions, and Certain Additional Drugs<br><br>Contact Express Scripts at (800) 753-2851 for preauthorization. | The plan will pay for FDA-approved specialty pharmaceuticals that meet the Plan's medical policy criteria for treatment of the condition. The prescribing physician must contact the Fund's pharmacy benefit manager (PBM) to request prior authorization of the drug(s). If preauthorization is not sought, the Plan will deny the claim and all charges will be the participant's responsibility. Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. The Plan in conjunction with its advisors and service providers determines which specific drugs are payable. This may include medications to treat hepatitis C, cystic fibrosis, rheumatoid arthritis, multiple sclerosis, and many other diseases, as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin. Prior authorization is required for compound drugs costing $100 or more. Express Scripts has also identified certain additional drugs that require preauthorization. These drugs have therapeutic equivalents with the same clinical efficacy that are available for a lower cost. | |
| Calendar Year Deductible | $400 Individual<br>$800 Family | |

| | | |
|---|---|---|
| Fixed dollar copays | $20 Physician Office,<br>$200 Emergency Room | |
| Co-Insurance | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket max; 100% thereafter. |
| Calendar Year Out-of-Pocket Maximum<br>(excludes deductible and copays) | $1,500 Individual<br>$3,000 Family<br>plus any balance bill amounts incurred for Out-of-Network charges. | |

| Benefit Item | In-Network | Out-of-Network |
|---|---|---|
| ***PREVENTIVE SERVICES*** | | |
| Health maintenance exam – Includes chest x-ray, EKG, cholesterol screening and other select lab procedures. One per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Gynecological Exam – One per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Pap smear screening – One per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Voluntary sterilization for females | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Well baby and child care visits[†]<br>• 7 visits, birth through 12 months<br>• 3 visits, 13 months through 23 months<br>• 3 visits, 24 months through 35 months<br>• 2 visits 36 months through 47 months<br>• Visits beyond 47 months are limited to one per participant per calendar year under the health maintenance exam benefit. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by the Plan that are in compliance with the provisions of the Patient Protection and Affordable Care Act | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Fecal occult blood screening – one per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Flexible sigmoidoscopy exam – one per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |

[†]In keeping with guidelines provided by the American Academy of Pediatricians, well baby visit: 1) through first 12 months modified from 6 visits to 7 effective 1/1/2017; 2) well baby visits from the 13th through the 35th month reduced from 6 to 3 visits per year effective 9/1/2018.

| | | |
|---|---|---|
| Prostate specific antigen (PSA) screening – one per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Routine mammogram and related reading – one per participant per year. Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. | Covered 100%<br>No deductible | Covered 100%<br>No deductible |
| Colonoscopy – routine or medically necessary – one per participant per year. Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. | Covered 100%<br>No deductible | Covered 100%<br>No deductible |
| Smoking cessation | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***PHYSICIAN OFFICE SERVICES*** | | |
| Outpatient Physician consultations & office visits | $20 Office Visit Copay | |
| Outpatient and medically necessary home medical care visits | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***TELEMEDICINE SERVICES*** | | |
| Telephone, online, or video conference with Physician | $0 Copay and Covered at 100% with no deductible | |
| ***URGENT AND EMERGENCY MEDICAL CARE*** | | |
| Emergency Room | $200 copay per visit. Covered at 80% up to out-of-pocket maximum; 100% thereafter. | $200 copay per visit. Covered at 80% up to out-of-pocket maximum; 100% thereafter. |
| Ambulance/Transportation | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Urgent care | $20 copay per visit Covered at 80% up to out-of-pocket maximum; 100% thereafter. | $20 copay per visit. Covered at 60% up to out-of-pocket maximum; 100% thereafter. |
| ***DIAGNOSTIC SERVICES*** | | |
| Diagnostic Lab & X-Ray | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***MATERNITY SERVICES PROVIDED BY A PHYSICIAN*** | | |
| Prenatal and post-natal care visits<br>(Dependent children are excluded from maternity services) | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Includes covered services provided by a certified nurse midwife | | |

| | | |
|---|---|---|
| Delivery and nursery care (Dependent children are excluded from maternity services) | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Includes covered services provided by a certified nurse midwife; | | |
| Inpatient maternity service charges for mothers covered as dependent children are excluded. | | |
| ***HOSPITAL CARE*** | | |
| Unlimited days in a semiprivate room, inpatient physician care, general nursing care, hospital services and supplies. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Inpatient maternity service charges for mothers covered as dependent children are excluded. | | |
| Inpatient consultations | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Chemotherapy – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***ALTERNATIVES TO HOSPITAL CARE*** | | |
| Skilled nursing care – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Hospice care – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Home infusion therapy – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***SURGICAL SERVICES*** | | |
| Surgery – includes related surgical services and medically necessary facility services at an approved ambulatory surgical center. Charges for services rendered by an assisting physician or surgeon may not exceed one third (1/3) the cost of the primary physician. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Pre-surgical consultations | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Voluntary sterilization for males | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***HUMAN ORGAN TRANSPLANTS*** | | |
| Organ & tissue transplants must be preauthorized. Transport and lodging limited to $10,000 per transplant. Donor search limited to $30,000 per transplant. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT*** | | |
| Mental health outpatient | 80% after deductible up to out- | 60% after deductible up to out-of- |

| | | |
|---|---|---|
| services | of-pocket maximum; 100% thereafter. | pocket maximum; 100% thereafter. |
| Substance abuse outpatient service | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Mental health inpatient services – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Substance abuse inpatient services – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Participant assistance program – Counseling sessions must be preauthorized. | 3 visits per incident. | Not covered. |

| ***AUTISM SPECTRUM DISORDERS, DIAGNOSIS AND TREATMENT PARTICIPANT REIMBURSEMENT PLAN*** | | |
|---|---|---|
| ***This benefit requires participants to pay for services and submit claims to the Fund Office for reimbursement. Please use the claim form, available in the Forms & Notices section of our web site at electricalfunds.org, when submitting a claim.*** | | |
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Applied behavioral analyses (ABA) treatment – limited to an annual maximum of $4,500 per participant through age 12 (limits may be waived on an individual consideration basis). | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Outpatient physical therapy, speech therapy, occupational; therapy, nutritional counseling for autism spectrum disorder – through age 12 subject to the combined $4,500 annual maximum. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Other covered services for autism spectrum disorder subject to the combined $4,500 annual maximum. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| **HEARING BENEFITS** | | |
| Audiometric exam – once every 36 months | Covered up to 100% of usual, customary and reasonable fee. | |
| Hearing aids – once every 36 months | Up to $800 per ear (No dollar limit for dependent children) | |
| ***OTHER COVERED SERVICES*** | | |
| Allergy testing & treatment | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Chiropractic & acupuncture – 18 visits per year without preauthorization – subsequent visits must be preauthorized or they will not be covered. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Oral Surgery related to accidents, tempo-mandibular | 80% after deductible up to out-of-pocket maximum; 100% | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |

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| joint repair and bruxism. | thereafter. | |
| Durable Medical Equipment; Prosthetics & Orthotics – preauthorization required for equipment in excess of $1,500. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Dialysis: Effective 10/1/2016, the Toledo Electrical Welfare Fund will no longer provide in-network dialysis coverage. Instead, dialysis coverage will be provided on an out-of-network basis or subject to a single case agreement with the treating provider. Please be advised that this change does not limit the types of dialysis services covered under the Plan. Instead, the change impacts the amount the Plan will pay a treating provider. This change does not apply to ongoing dialysis cases initiated prior to 10/1/2016. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Home Health Care & Medically Necessary Private Duty Nursing – must be preauthorized or services are not covered. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Lasik Eye surgery – up to $500 per eye per lifetime (Primary Participant Only). | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Dental services for accidental injury and other related medical services limited to $3,000 per calendar year. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Diabetic supplies – insulin, syringes, lancet and test strips. | Covered at 100% of usual, customary and reasonable charges. | |

| ***PRESCRIPTION DRUG BENEFITS ADMINISTERED BY EXPRESS SCRIPTS*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Prior authorization | Preauthorization must be obtained for specialty drugs and for compound drugs costing $100 or more. Certain additional drugs that have therapeutic equivalents for lower cost also require prior authorization. | |
| Days' supply limits | Up to 30, 60 or 90-day supply for non-specialty drugs. 30 days for specialty drugs. | |
| Preventive services as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by the Plan that are in compliance with the provisions of the Patient Protection and Affordable Care Act including, but not limited to: | Covered 100%; no copay | Not covered |

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| - Aspirin to prevent cardiovascular disease<br>- Breast cancer prevention drugs<br>- Iron supplementation in children<br>- Oral fluorides for children<br>- Tobacco cessation (one 180-day course or treatment per year)<br>- Routine vaccinations for children & adults<br>- Effective 12/1/2017 certain low to moderate dosage statins for those age 40 to 75 | | |
| Contraceptives including: Oral, transdermal, vaginal, IUD, implant, and diaphragms. | Covered 100%; no copay | Not covered |
| Copays* up to $1,000 annual out-of-pocket maximum. One copay per 30-day supply. | $10 generic, $30 brand, $50 non-preferred brand or specialty (see NOTE below) | $10 generic, $30 brand, $50 non-preferred brand or specialty; participants will have to submit a claim for reimbursement when using a non-network pharmacy. |
| Copays* after $1,000 annual out-of-pocket maximum. One copay per 30-day supply. | $0 generic, $10 brand, $25 non-preferred brand or specialty (see NOTE below) | $0 generic, $10 brand, $25 non-preferred brand or specialty; participants will have to submit a claim for reimbursement when using a non-network pharmacy. |

*Kroger pharmacies will discount all co-payments by one dollar ($1) and will allow ninety (90) day drug supplies.

NOTE: If you choose a brand name drug over a generic drug, you are responsible for the generic drug co-payment plus the difference in cost between the brand and generic drug.

| ***DENTAL BENEFITS ADMINISTERED BY DELTA DENTAL*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Calendar Year Deductible | $25 per participant | The Plan contracts with the Delta Dental PPO and Premier networks. There is not a requirement to use the Delta Dental networks, but there may be a financial advantage in doing so. When obtaining services from a Delta Dental provider the participant is assured the Plan's payment for covered services along with any participant fee responsibilities (deductibles or coinsurance) will be accepted by the Delta Dental provider as full payment. |
| Calendar year maximum benefit | $1,250 per participant | |
| Preventive Services (Exam & cleaning) | Covered at 100%; no deductible | |
| Diagnostic services (X-Rays) | 85% after deductible | |
| Restorative & endodontic services (fillings, crowns, root canals) | 85% after deductible | |
| Prosthodontic (Dentures) | 50% after deductible | |
| Orthodontic up to age 19 (Braces) (effective 2/1/2015) | 50% after deductible subject to lifetime maximum of $2,500 | |

| *VISION BENEFITS ADMINISTERED BY VSP* | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network Reimbursement** |
| Adult Eye exam – once every 24 months<br>Dependent Child – once every 12 months | $10 copay | Plan pays up to $35 per visit |
| Adult Prescription lenses – once every 24 months<br>Dependent Child Prescription Lenses – once every 12 months | Single vision, Lined Bifocal, Lined Trifocal and Polycarbonate lenses for dependent children: $25 copay; additional copays apply for optional lenses:<br>Standard Progressive Lenses: $50<br>Premium Progressive Lenses: $80-90<br>Custom Progressive Lenses: $120-160<br>Average 35-40% off other lens options. | Single vision up to $25<br>Bifocal lenses up to $40<br>Trifocal lenses up to $55<br>Lenticular lenses up to $80 |
| Adult Frames – once every 24 months if frame is obtained in-network, no out-of-pocket expenses other than the copayment will apply. The wholesale cost of the frame cannot exceed the Wholesale Network Frame Allowance. Same rules apply for Dependent Child Frames, but benefit allows for frames every 12 months. | Frame allowance $170; 20% off amount over your allowance | Frame benefit $45<br>Frame allowance N/A |
| Adult Contact lenses – once every 24 months<br>Dependent Child Contact lenses – once every 12 months – can be chosen in lieu of lenses and frames. | Medically necessary: 100%<br>Elective: up to $120 Allowance; 15% off contact lens exam (fitting and evaluation). | Medically necessary: up to $210<br>Elective: up to $105 |
| Prescription Safety Glasses – Active Employee Only – Once every 24 Months. | $25 copay | Covered after $25 copay up to VSP approved amount |
| Low Vision Benefit – available to participants with severe visual problems not correctable with regular lenses. (Maximum benefit $1,000 per participant every two years). | Supplementary testing covered in full; supplemental care aids covered at 75% of cost. | Supplementary testing covered up to $125: supplemental care aids covered at 75% of cost. |
| Additional Coverage, Savings and Discounts | Diabetic Eyecare Program, 30% off additional glasses and sunglasses. 20% off VSP doctor within 12 months of your last Well Vision Exam, guaranteed pricing on retinal screening, discounts on Laser Vision Correction. | |

| ***LIFE INSURANCE AND ADD*** | |
|---|---|
| Death Benefit | $10,000 |
| Accidental death and dismemberment | Loss of life: $10,000<br>Loss of two limbs: $10,000<br>Loss of sight both eyes: $10,000<br>Loss of one limb and sight in one eye: $10,000<br>Loss of one limb: $5,000<br>Loss of sight in one eye: $5,000 |

| ***SHORT TERM DISABILITY*** | |
|---|---|
| Weekly income benefit | Up to 30% of the journeyman class 1 wage (for Journeymen and Apprentices) or the Class 26 Employee's own wage per week paid the first day for an accident, and after a 1 week waiting period is satisfied for a illness that is non-occupational for up to 26 weeks. |

| ***TOTALLY & PERMANENTLY DISABLED*** | |
|---|---|
| All listed benefits **except** | Vision, Dental, Short Term Disability and Life and ADD. |
| Death Benefit | $1,000 |

| ***SURVIVING SPOUSES -- PLEASE SEE PLAN R*** | | |
|---|---|---|
| All listed benefits **except** | Vision, Dental 1250, Short Term Disability and Life and ADD. | |
| Dental Benefits | Surviving Spouses are eligible for Dental 250. | |
| ***SURVIVING SPOUSE DENTAL 250 BENEFITS ADMINISTERED BY DELTA DENTAL*** | | |
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Calendar Year Deductible | $25 per participant | The Plan contracts with the Delta Dental PPO and Premier networks. There is not a requirement to use the Delta Dental networks, but there may be a financial advantage in doing so. When obtaining services from a Delta Dental provider the participant is assured the Plan's payment for covered services along with any participant fee responsibilities (deductibles or coinsurance) will be accepted by the Delta Dental provider as full payment. |
| Calendar year maximum benefit | $250 per participant | |
| Preventive Services (Exam & cleaning) | Covered at 100%; no deductible | |
| Diagnostic services (X-Rays) | 85% after deductible | |
| ***ALTERNATIVE OPT-OUT PROGRAMS*** | | |
| **Participants with other coverage may opt-out of the benefit plan without forfeiting their right to re-enter the plan if they experience a qualifying event that leads to the loss of their alternative coverage.** | | |
| Active Opt-Out | Actives that opt-out are still covered for Hearing, Vision, EAP, Dental, Short Term Disability, Life Insurance and ADD. | |
| Surviving Spouse Opt-Out with Vision and Dental | Surviving Spouses that choose this option are still covered for Vision, EAP and Dental. | |
| Surviving Spouse Opt-Out | Surviving Spouses that opt-out of the benefit plan are eligible for qualifying medical expense reimbursement up to $300 for a single participant or $600 per family participant per calendar year. | |

## Plan B Schedule of Benefits

*Please Note: for most Out-of-Network services listed in this schedule, Balance Bills, if any, are not covered.*

| Benefit Item | In-Network | Out-of-Network |
|---|---|---|
| Lifetime Plan Maximum | None | |
| Participant Responsibility | Deductibles, copays, coinsurance and out-of-pocket maximums. If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable cost sharing including potential balance bill amounts except in certain circumstances Effective for any procedures with a date of service on or after January 1, 2016, the Toledo Electrical Welfare Fund will cover out-of-network physician, radiology, pathology, and anesthesiology services rendered at an in-network facility at the in-network rate. In other words, if you received these services at an in-network facility but were subjected to out-of-network charges, the Funds Office will reassess the claim and make an additional payment to the provider. Please review your Explanation of Benefits notices after receiving medical services to determine whether this has occurred and contact the Funds Office for additional claims review. | |
| Utilization Review<br>Prior Authorization Requirement | A penalty may apply if your provider fails to obtain prior authorization from the Plan's utilization review vendor for all inpatient (including maternity), inpatient physician, or any chiropractic, surgical, diagnostic, x-ray, therapy, durable medical equipment or intensive outpatient substance abuse services. Home health, home infusion services and hospice care are not covered without prior authorization. | |
| Preauthorization for Specialty Pharmaceuticals, Compound Prescriptions, and Certain Additional Drugs<br><br>Contact Express Scripts at (800) 753-2851 for preauthorization. | The plan will pay for FDA-approved specialty pharmaceuticals that meet the Plan's medical policy criteria for treatment of the condition. The prescribing physician must contact the Fund's pharmacy benefit manager (PBM) to request prior authorization of the drug(s). If preauthorization is not sought, the Plan will deny the claim and all charges will be the participant's responsibility. Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. The Plan in conjunction with its advisors and service providers determines which specific drugs are payable. This may include medications to treat hepatitis C, cystic fibrosis, rheumatoid arthritis, multiple sclerosis, and many other diseases, as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin. Prior authorization is required for compound drugs costing $100 or more. Express Scripts has also identified certain additional drugs that require preauthorization. These drugs have therapeutic equivalents with the same clinical efficacy that are available for a lower cost. | |
| Calendar Year Deductible | $2,500 Individual<br>$5,000 Family | $5,000 Individual<br>$10,000 Family |

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| Fixed dollar copays | $30 Physician Office, $50 Urgent Care, and $100 Emergency Room | |
| Co-Insurance | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Calendar Year Out-of-Pocket Maximum (excludes deductible and copays)<br>Total in-network, out-of-pocket expense not to exceed $2,500 individual/$5,000 family per calendar year. | $1,500 Individual<br>$3,000 Family | $2,500 Individual<br>$5,000 Family<br><br>Plus any balance bill amounts incurred for Out-of-Network charges. |

| Benefit Item | In-Network | Out-of-Network |
|---|---|---|
| ***PREVENTIVE SERVICES*** | | |
| Health maintenance exam – Includes chest x-ray, EKG, cholesterol screening and other select lab procedures. One per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Gynecological Exam – One per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Pap smear screening – One per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Voluntary sterilization for females | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Well baby and child care visits‡<br>• 7 visits, birth through 12 months<br>• 3 visits, 13 months through 23 months<br>• 3 visits, 24 months through 35 months<br>• 2 visits 36 months through 47 months<br>• Visits beyond 47 months are limited to one per participant per calendar year under the health maintenance exam benefit | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by the Plan that are in compliance with the provisions of the Patient Protection and Affordable Care Act | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Fecal occult blood screening - one per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |

‡In keeping with guidelines provided by the American Academy of Pediatricians, well baby visit: 1) through first 12 months modified from 6 visits to 7 effective 1/1/2017; 2) well baby visits from the 13th through the 35th month reduced from 6 to 3 visits per year effective 9/1/2018.

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| Flexible sigmoidoscopy exam- one per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Prostate specific antigen (PSA) screening- one per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Routine mammogram and related reading- one per participant per year. Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. | Covered 100%<br>No deductible | Covered 100%<br>No deductible |
| Colonoscopy – routine or medically necessary- one per participant per year. Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. | Covered 100%<br>No deductible | Covered 100%<br>No deductible |
| Smoking cessation | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***PHYSICIAN OFFICE SERVICES*** | | |
| Outpatient Physician office visits | $30 Office Visit Copay | |
| Outpatient and medically necessary home medical care visits | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***TELEMEDICINE SERVICES*** | | |
| Telephone, online, or video conference with Physician | $0 Copay and Covered at 100% with no deductible | |
| ***URGENT AND EMERGENCY MEDICAL CARE*** | | |
| Emergency Room | $100 copay per visit. Covered at 70% up to out-of-pocket maximum; 100% thereafter. | $100 copay per visit. Covered at 70% up to out-of-pocket maximum; 100% thereafter. |
| Ambulance/Transportation | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Urgent care | $50 copay per visit Covered at 70% up to out-of-pocket maximum; 100% thereafter. | $50 copay per visit. Covered at 60% up to out-of-pocket maximum; 100% thereafter. |
| ***DIAGNOSTIC SERVICES*** | | |
| Diagnostic Lab & X-Ray | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***MATERNITY SERVICES PROVIDED BY A PHYSICIAN*** | | |
| Prenatal and post-natal care visits (Dependent children are excluded from maternity services) | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Includes covered services provided by a certified nurse midwife. | | |
| Delivery and nursery care (Dependent children are excluded from maternity services) | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Includes covered services provided by a certified nurse midwife. | | |
| Inpatient maternity service charges for mothers covered as dependent children are excluded. | | |

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| ***HOSPITAL CARE*** | | |
| Unlimited days in a semiprivate room, inpatient physician care, general nursing care, hospital services and supplies. | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Inpatient maternity service charges for mothers covered as dependent children are excluded. | | |
| Inpatient consultations | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Chemotherapy – must be preauthorized | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***ALTERNATIVES TO HOSPITAL CARE*** | | |
| Skilled nursing care – must be preauthorized<br>*Capped at 90 days per calendar year. | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Hospice care – must be preauthorized | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Home infusion therapy – must be preauthorized | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***SURGICAL SERVICES*** | | |
| Surgery – includes related surgical services and medically necessary facility services at an approved ambulatory surgical center. Charges for services rendered by an assisting physician or surgeon may not exceed one third (1/3) the cost of the primary physician. | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Pre-surgical consultations | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Voluntary sterilization for males | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***HUMAN ORGAN TRANSPLANTS*** | | |
| Organ & tissue transplants must be preauthorized. Transport and lodging limited to $10,000 per transplant. Donor search limited to $30,000 per transplant. | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT*** | | |
| Mental health outpatient services | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Substance abuse outpatient service | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Mental health inpatient services – must be preauthorized | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |

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| Substance abuse inpatient services – must be preauthorized | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Participant assistance program – Counseling sessions must be preauthorized. | 3 visits per incident. | Not covered. |

| ***AUTISM SPECTRUM DISORDERS, DIAGNOSIS AND TREATMENT PARTICIPANT REIMBURSEMENT PLAN*** | | |
|---|---|---|
| ***This benefit requires participants to pay for services and submit claims to the Fund Office for reimbursement. Please use the claim form, available in the Forms & Notices section of our web site at electricalfunds.org, when submitting a claim.*** | | |
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Applied behavioral analyses (ABA) treatment – limited to an annual maximum of $4,500 per participant through age 12 (limits may be waived on an individual consideration basis). | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Outpatient physical therapy, speech therapy, occupational; therapy, nutritional counseling for autism spectrum disorder – through age 12 subject to the combined $4,500 annual maximum. | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Other covered services for autism spectrum disorder subject to the combined $4,500 annual maximum. | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| **HEARING BENEFITS** | | |
| Audiometric exam – once every 36 months | Covered up to 100% of usual, customary and reasonable fee. | |
| Hearing aids – once every 36 months | Up to $800 per ear (No dollar limit for dependent children). | |
| ***OTHER COVERED SERVICES*** | | |
| Allergy testing & treatment | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Chiropractic & acupuncture – 18 visits per year without preauthorization – subsequent visits must be preauthorized or they will not be covered. | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Oral Surgery related to accidents, tempo-mandibular joint repair and bruxism | 70% after deductible up to out-of-pocket maximum; 100% thereafter | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Durable Medical Equipment; Prosthetics & Orthotics – preauthorization required for equipment in excess of $1,500. | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Dialysis: Effective 10/1/2016, the Toledo Electrical Welfare Fund will no longer provide in-network dialysis coverage. Instead, dialysis coverage will be provided on an out-of-network basis or subject to a single case | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |

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| agreement with the treating provider. Please be advised that this change does not limit the types of dialysis services covered under the Plan. Instead, the change impacts the amount the Plan will pay a treating provider. This change does not apply to ongoing dialysis cases initiated prior to 10/1/2016. | | |
| Home Health Care & Medically Necessary Private Duty Nursing – must be preauthorized or services are not covered. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| | Home Health Care limited to 100 visits per year; Private Duty Nursing limited to $50,000 per calendar year. | |
| Lasik Eye surgery – up to $500 per eye per lifetime (Primary Participant Only). | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Dental services for accidental injury and other related medical services limited to $3,000 per calendar year. | 70% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Diabetic supplies – insulin, syringes, lancet and test strips. | Covered at 100% of usual, customary and reasonable charges. | |

| ***PRESCRIPTION DRUG BENEFITS ADMINISTERED BY EXPRESS SCRIPTS*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Prior authorization | Preauthorization must be obtained for specialty drugs and for compound drugs costing $100 or more. Certain additional drugs that have therapeutic equivalents for lower cost also require prior authorization. | |
| Days' supply limits | Up to 30, 60 or 90-day; 30-day supply limit for specialty drugs. | |
| Preventive services as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by the Plan that are in compliance with the provisions of the Patient Protection and Affordable Care Act including, but not limited to:<br>- Aspirin to prevent cardiovascular disease<br>- Breast cancer prevention drugs<br>- Iron supplementation in children<br>- Oral fluorides for children<br>- Tobacco cessation (one 180-day course or treatment per year)<br>- Routine vaccinations for children & adults<br>- Effective 12/1/2017 certain low to moderate dosage statins for those age 40 to 75 | Covered 100%; no copay | Not covered |
| Contraceptives including:<br>Oral, transdermal, vaginal, IUD, implant, and diaphragms | Covered 100%; no copay | Not covered |

| | | |
|---|---|---|
| Copays* up to $1,000 annual out-of-pocket maximum.<br>One copay per 30-day supply. | $10 generic, $30 brand, $50 non-preferred brand or specialty<br>(see NOTE below) | $10 generic, $30 brand, $50 non-preferred brand or specialty; participants will have to submit a claim for reimbursement when using a non-network pharmacy. |
| Copays* after $1,000 annual out-of-pocket maximum.<br>One copay per 30-day supply. | $0 generic, $10 brand, $25 non-preferred brand or specialty<br>(see NOTE below) | $0 generic, $10 brand, $25 non-preferred brand or specialty; participants will have to submit a claim for reimbursement when using a non-network pharmacy. |

*Kroger pharmacies will discount all co-payments by one dollar ($1) and will allow ninety (90) day drug supplies.

NOTE: If you choose a brand name drug over a generic drug, you are responsible for the generic drug co-payment plus the difference in cost between the brand and generic drug.

| ***DEPENDENT CHILD DENTAL BENEFITS ADMINISTERED BY DELTA DENTAL*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Calendar Year Deductible | $0 | The Plan contracts with the Delta Dental PPO and Premier networks. There is not a requirement to use the Delta Dental networks, but there may be a financial advantage in doing so. When obtaining services from a Delta Dental provider the participant is assured the Plan's payment for covered services along with any participant fee responsibilities (deductibles or coinsurance) will be accepted by the Delta Dental provider as full payment. |
| Calendar year maximum benefit | Unlimited | |
| Preventive Services (Exam & cleaning) | Covered at 100%; no deductible | |

| ***VISION BENEFITS ADMINISTERED BY VSP*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network Reimbursement** |
| Adult Eye exam – once every 24 months<br>Dependent Child – once every 12 months | $10 copay | Plan pays up to $35 per visit |
| Adult Prescription lenses – once every 24 months<br>Dependent Child Prescription Lenses – once every 12 months | Single vision, Lined Bifocal, Lined Trifocal and Polycarbonate lenses for dependent children: $25 copay; additional copays apply for optional lenses:<br>Standard Progressive Lenses: $50<br>Premium Progressive Lenses: $80-90<br>Custom Progressive Lenses: $120-160 | Single vision up to $25<br>Bifocal lenses up to $40<br>Trifocal lenses up to $55<br>Lenticular lenses up to $80 |

| | | |
|---|---|---|
| | Average 35-40% off other lens options. | |
| Adult Frames – once every 24 months if frame is obtained in-network, no out-of-pocket expenses other than the copayment will apply. The wholesale cost of the frame cannot exceed the Wholesale Network Frame Allowance. Same rules apply for Dependent Child Frames, but benefit allows for frames every 12 months. | Frame allowance $170; 20% off amount over your allowance. | Frame benefit $45<br>Frame allowance N/A |
| Adult Contact lenses – once every 24 months<br>Dependent Child Contact lenses – once every 12 months – can be chosen in lieu of lenses and frames. | Medically necessary: 100%<br>Elective: up to $120<br>Allowance; 15% off contact lens exam (fitting and evaluation). | Medically necessary: up to $210<br>Elective: up to $105 |
| Low Vision Benefit – available to participants with severe visual problems not correctable with regular lenses. (Maximum benefit $1,000 per participant every two years). | Supplementary testing covered in full; supplemental care aids covered at 75% of cost. | Supplementary testing covered up to $125: supplemental care aids covered at 75% of cost. |
| Additional Coverage, Savings and Discounts. | Diabetic Eyecare Program, 30% off additional glasses and sunglasses. 20% off VSP doctor within 12 months of your last Well Vision Exam, guaranteed pricing on retinal screening, discounts on Laser Vision Correction. | |

## Plan R Schedule of Benefits

*Please Note: for most Out-of-Network services listed in this schedule, Balance Bills, if any, are not covered.*

| Benefit Item | In-Network | Out-of-Network |
|---|---|---|
| Lifetime Plan Maximum | None | |
| Participant Responsibility | Deductibles, copays, coinsurance and out-of-pocket maximums. If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable cost sharing including potential balance bill amounts except in certain circumstances Effective for any procedures with a date of service on or after January 1, 2016, the Toledo Electrical Welfare Fund will cover out-of-network physician, radiology, pathology, and anesthesiology services rendered at an in-network facility at the in-network rate. In other words, if you received these services at an in-network facility but were subjected to out-of-network charges, the Funds Office will reassess the claim and make an additional payment to the provider. Please review your Explanation of Benefits notices after receiving medical services to determine whether this has occurred and contact the Funds Office for additional claims review. | |
| Utilization Review<br>Prior Authorization Requirement | A penalty may apply if your provider fails to obtain prior authorization from the Plan's utilization review vendor for all inpatient (including maternity), inpatient physician, or any chiropractic, surgical, diagnostic, x-ray, therapy, durable medical equipment or intensive outpatient substance abuse services. Home health, home infusion services and hospice care are not covered without prior authorization | |
| Preauthorization for Specialty Pharmaceuticals, Compound Prescriptions, and Certain Additional Drugs<br><br>Contact Express Scripts at (800) 753-2851 for preauthorization. | The plan will pay for FDA-approved specialty pharmaceuticals that meet the Plan's medical policy criteria for treatment of the condition. The prescribing physician must contact the Fund's pharmacy benefit manager (PBM) to request prior authorization of the drug(s). If preauthorization is not sought, the Plan will deny the claim and all charges will be the participant's responsibility. Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. The Plan in conjunction with its advisors and service providers determines which specific drugs are payable. This may include medications to treat hepatitis C, cystic fibrosis, rheumatoid arthritis, multiple sclerosis, and many other diseases, as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin. Prior authorization is required for compound drugs costing $100 or more. Express Scripts has also identified certain additional drugs that require preauthorization. These drugs have therapeutic equivalents with the same clinical efficacy that are available for a lower cost. | |
| Calendar Year Deductible | $400 Individual<br>$800 Family | |

| | | |
|---|---|---|
| Fixed dollar copays | $20 Physician Office,<br>$200 Emergency Room | |
| Co-Insurance | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Calendar Year Out-of-Pocket Maximum (excludes deductible and copays) | $1,500 Individual<br>$3,000 Family<br>plus any balance bill amounts incurred for Out-of-Network charges. | |

| Benefit Item | In-Network | Out-of-Network |
|---|---|---|
| ***PREVENTIVE SERVICES*** | | |
| Health maintenance exam – Includes chest x-ray, EKG, cholesterol screening and other select lab procedures. One per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Gynecological Exam – One per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Pap smear screening – One per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Voluntary sterilization for females | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Well baby and child care visits[§]<br>• 7 visits, birth through 12 months<br>• 3 visits, 13 months through 23 months<br>• 3 visits, 24 months through 35 months<br>• 2 visits 36 months through 47 months<br>• Visits beyond 47 months are limited to one per participant per calendar year under the health maintenance exam benefit | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by the Plan that are in compliance with the provisions of the Patient Protection and Affordable Care Act | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Fecal occult blood screening - one per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Flexible sigmoidoscopy exam- one per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |

[§]In keeping with guidelines provided by the American Academy of Pediatricians, well baby visit: 1) through first 12 months modified from 6 visits to 7 effective 1/1/2017; 2) well baby visits from the 13th through the 35th month reduced from 6 to 3 visits per year effective 9/1/2018.

| | | |
|---|---|---|
| Prostate specific antigen (PSA) screening – one per participant per year. | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. . |
| Routine mammogram and related reading – one per participant per year. Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. | Covered 100%<br>No deductible | Covered 100%<br>No deductible |
| Colonoscopy – routine or medically necessary- one per participant per year. Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. | Covered 100%<br>No deductible | Covered 100%<br>No deductible |
| Smoking cessation | Covered 100%<br>No deductible | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***PHYSICIAN OFFICE SERVICES*** | | |
| Outpatient Physician consultations & office visits | $20 Office Visit Copay | |
| Outpatient and medically necessary home medical care visits. | 80% after deductible up to out-of-pocket maximum; 100% thereafter | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***TELEMEDICINE SERVICES*** | | |
| Telephone, online, or video conference with Physician | $0 Copay and Covered at 100% with no deductible | |
| ***URGENT AND EMERGENCY MEDICAL CARE*** | | |
| Emergency Room | $200 copay per visit. Covered at 80% up to out-of-pocket maximum; 100% thereafter. | $200 copay per visit. Covered at 80% up to out-of-pocket maximum; 100% thereafter. |
| Ambulance/Transportation | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Urgent care | $20 copay per visit Covered at 80% up to out-of-pocket maximum; 100% thereafter. | $20 copay per visit. Covered at 60% up to out-of-pocket maximum; 100% thereafter. |
| ***DIAGNOSTIC SERVICES*** | | |
| Diagnostic Lab & X-Ray | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***MATERNITY SERVICES PROVIDED BY A PHYSICIAN*** | | |
| Prenatal and post-natal care visits (Dependent children are excluded from maternity services) | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Includes covered services provided by a certified nurse midwife | | |
| Delivery and nursery care (Dependent children are excluded from maternity services) | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Includes covered services provided by a certified nurse midwife. | | |
| Inpatient maternity service charges for mothers covered as dependent children are excluded. | | |

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| ***HOSPITAL CARE*** | | |
| Unlimited days in a semiprivate room, inpatient physician care, general nursing care, hospital services and supplies. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Inpatient maternity service charges for mothers covered as dependent children are excluded. | | |
| Inpatient consultations | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Chemotherapy – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***ALTERNATIVES TO HOSPITAL CARE*** | | |
| Skilled nursing care – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Hospice care – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Home infusion therapy – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***SURGICAL SERVICES*** | | |
| Surgery – includes related surgical services and medically necessary facility services at an approved ambulatory surgical center. Charges for services rendered by an assisting physician or surgeon may not exceed one third (1/3) the cost of the primary physician. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Pre-surgical consultations | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Voluntary sterilization for males | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***HUMAN ORGAN TRANSPLANTS*** | | |
| Organ & tissue transplants must be preauthorized. Transport and lodging limited to $10,000 per transplant. Donor search limited to $30,000 per transplant. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| ***MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT*** | | |
| Mental health outpatient services | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Substance abuse outpatient service | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Mental health inpatient services – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Substance abuse inpatient services – must be preauthorized | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |

| | | |
|---|---|---|
| Participant assistance program – Counseling sessions must be preauthorized | 3 visits per incident. | Not covered. |

| ***AUTISM SPECTRUM DISORDERS, DIAGNOSIS AND TREATMENT PARTICIPANT REIMBURSEMENT PLAN*** | | |
|---|---|---|
| ***This benefit requires participants to pay for services and submit claims to the Fund Office for reimbursement. Please use the claim form, available in the Forms & Notices section of our web site at electricalfunds.org, when submitting a claim.*** | | |
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Applied behavioral analyses (ABA) treatment – limited to an annual maximum of $4,500 per participant through age 12 (limits may be waived on an individual consideration basis). | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Outpatient physical therapy, speech therapy, occupational; therapy, nutritional counseling for autism spectrum disorder – through age 12 subject to the combined $4,500 annual maximum. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Other covered services for autism spectrum disorder subject to the combined $4,500 annual maximum. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| **HEARING BENEFITS** | | |
| Audiometric exam – once every 36 months | Covered up to 100% of usual, customary and reasonable fee. | |
| Hearing aids – once every 36 months | Up to $800 per ear (No dollar limit for dependent children) | |
| ***OTHER COVERED SERVICES*** | | |
| Allergy testing & treatment | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Chiropractic & acupuncture – 18 visits per year without preauthorization – subsequent visits must be preauthorized or they will not be covered. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Oral Surgery related to accidents, tempo-mandibular joint repair and bruxism | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Durable Medical Equipment; Prosthetics & Orthotics – preauthorization required for equipment in excess of $1,500. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Dialysis: Effective 10/1/2016, the Toledo Electrical Welfare Fund will no longer provide in-network dialysis coverage. Instead, dialysis coverage will be provided on an out-of-network basis or subject to a single case agreement with the treating provider. Please be advised that this change does not limit the types of dialysis services covered under the Plan. Instead, the change impacts the amount the Plan will pay a treating provider. This change does not apply to | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |

| | | |
|---|---|---|
| ongoing dialysis cases initiated prior to 10/1/2016. | | |
| Home Health Care & Medically Necessary Private Duty Nursing – must be preauthorized or services are not covered. | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Lasik Eye surgery – up to $500 per eye per lifetime (Primary Participant Only) | 80% after deductible up to out-of-pocket maximum; 100% thereafter. | 60% after deductible up to out-of-pocket maximum; 100% thereafter. |
| Diabetic supplies – insulin, syringes, lancet and test strips | Covered at 100% of usual, customary and reasonable charges. | |

| ***PRESCRIPTION DRUG BENEFITS ADMINISTERED BY EXPRESS SCRIPTS*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Prior authorization | Preauthorization must be obtained for specialty drugs and for compound drugs costing $100 or more. Certain additional drugs that have therapeutic equivalents for lower cost also require prior authorization. | |
| Days' supply limits | Up to 30, 60 or 90-day supply for non-specialty drugs. 30 days for specialty drugs. | |
| Preventive services as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by the Plan that are in compliance with the provisions of the Patient Protection and Affordable Care Act including, but not limited to:<br>- Aspirin for cardiovascular disease<br>- Breast cancer prevention drugs<br>- Iron supplementation in children<br>- Oral fluorides for children<br>- Tobacco cessation (one 180-day course or treatment per year)<br>- Routine vaccinations for children & adults<br>- Effective 12/1/2017 certain low to moderate dosage statins for those age 40 to 75 | Covered 100%; no copay | Not covered |
| Contraceptives including: Oral, vaginal, transdermal, IUD, implant, diaphragms | Covered 100%; no copay | Not covered |
| Copays* up to $1,000 annual out-of-pocket maximum.<br>One copay per 30-day supply. | $10 generic, $30 brand, $50 non-preferred brand or specialty<br>(see NOTE below) | $10 generic, $30 brand, $50 non-preferred brand or specialty; participants must submit a claim for reimbursement when using a non-network pharmacy |
| Copays* after $1,000 annual out-of-pocket maximum.<br>One copay per 30-day supply. | $0 generic, $10 brand, $25 non-preferred brand or specialty<br>(see NOTE below) | $0 generic, $10 brand, $25 non-preferred brand or specialty; participants must submit a claim for reimbursement when using a non-network pharmacy |

*Kroger pharmacies will discount all co-payments by one dollar ($1) and will allow ninety (90) day drug supplies.

NOTE: If you choose a brand name drug over a generic drug, you are responsible for the generic drug co-payment plus the difference in cost between the brand and generic drug.

| ***DENTAL 250 BENEFITS ADMINISTERED BY DELTA DENTAL*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network Reimbursement** |
| Calendar year Deductible | $25 per individual | The Plan contracts with the Delta Dental PPO and Premier networks. There is not a requirement to use the Delta Dental networks, but there may be a financial advantage in doing so. When obtaining services from a Delta Dental provider the participant is assured the Plan's payment for covered services along with any participant fee responsibilities (deductibles or coinsurance) will be accepted by the Delta Dental provider as full payment. |
| Calendar year maximum benefit | $250 per individual | |
| Preventive Services (exam and cleaning) | Covered at 100%, no deductible | |
| Diagnostic Services (x-rays) | 85% after deductible | |

| ***VISION BENEFITS ADMINISTERED BY VSP*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network Reimbursement** |
| Adult Eye exam – once every 24 months<br>Dependent Child – once every 12 months | $10 copay | Plan pays up to $35 per visit |
| Adult Prescription lenses – once every 24 months<br>Dependent Child Prescription Lenses – once every 12 months | Single vision, Lined Bifocal, Lined Trifocal and Polycarbonate lenses for dependent children: $25 copay; additional copays apply for optional lenses:<br>Standard Progressive Lenses: $50<br>Premium Progressive Lenses: $80-90<br>Custom Progressive Lenses: $120-160<br>Average 35-40% off other lens options. | Single vision up to $25<br>Bifocal lenses up to $40<br>Trifocal lenses up to $55<br>Lenticular lenses up to $80 |
| Adult Frames – once every 24 months if frame is obtained in-network, no out-of-pocket expenses other than the copayment will apply. The wholesale cost of the frame cannot exceed the Wholesale Network Frame Allowance. Same rules apply for Dependent Child Frames, but benefit allows for frames every 12 months | Frame allowance $170; 20% off amount over your allowance | Frame benefit $45<br>Frame allowance N/A |
| Adult Contact lenses – once every 24 months<br>Dependent Child Contact lenses – once every 12 months -- can be chosen in | Medically necessary: 100%<br>Elective: up to $120 Allowance; 15% off contact lens exam (fitting and | Medically necessary: up to $210<br>Elective: up to $105 |

| | | |
|---|---|---|
| lieu of lenses and frames | evaluation) | |
| Low Vision Benefit - available to participants with severe visual problems not correctable with regular lenses. (Maximum benefit $1,000 per participant every two years) | Supplementary testing covered in full; supplemental care aids covered at 75% of cost | Supplementary testing covered up to $125: supplemental care aids covered at 75% of cost. |
| Additional Coverage, Savings and Discounts | Diabetic Eyecare Program, 30% off additional glasses and sunglasses. 20% off VSP doctor within 12 months of your last Well Vision Exam, guaranteed pricing on retinal screening, discounts on Laser Vision Correction | |

| ***LIFE INSURANCE AND ADD*** | |
|---|---|
| Death Benefit | **$2,000** |

| ***SURVIVING SPOUSES*** | |
|---|---|
| All listed benefits except Vision, Short-term Disability, and Death Benefit. | |
| ***ALTERNATIVE OPT-OUT PROGRAMS*** | |
| **Participants with other coverage may opt-out of the benefit plan without forfeiting their right to re-enter the plan if they experience a qualifying event that leads to the loss of their alternative coverage.** | |
| Early Retiree Opt-Out | Up to $5,000 in qualifying medical expense reimbursement per calendar year. |

**Plan M Schedule of Benefits**

*Please Note: for most Out-of-Network services listed in this schedule, Balance Bills, if any, are not covered*

| Benefit Item | Description |
|---|---|
| Lifetime Plan Maximum | None |
| Coordination with Medicare | As a Participant who is eligible for Medicare benefits your benefits from Medicare are primary and the Plan pays secondary to Medicare. You are entitled to the benefits described below; however, the benefits the plan pays will be reduced by the amount paid by Medicare. You are also entitled to the benefits below even if those services are not covered by Medicare. In no instance will you, or a provider, receive benefits greater than listed below from the plan. |
| Medicare Participating Providers | If your providers participate with Medicare then they must accept the Medicare allowed amount as reasonable payment in-full, assuming it is a covered service under Medicare. You may however be subject to any Medicare deductibles, co-pays or coinsurance. Your benefits under this plan – after Medicare pays – will be determined based on whether the provider is considered In-Network, Out-of-Network Discounted, or Out-of-Network Non-Discounted as described below. |
| Participant Responsibility | Deductibles, copays, coinsurance and out-of-pocket maximums. If an in-network provider refers you to a non-discounted provider, all covered services obtained from that non-discounted provider will be subject to applicable cost sharing, including potential balance bill amounts except in certain circumstances Effective for any procedures with a date of service on or after January 1, 2016, the Toledo Electrical Welfare Fund will cover out-of-network physician, radiology, pathology, and anesthesiology services rendered at an in-network facility at the in-network rate. In other words, if you received these services at an in-network facility but were subjected to out-of-network charges, the Funds Office will reassess the claim and make an additional payment to the provider. Please review your Explanation of Benefits notices after receiving medical services to determine whether this has occurred and contact the Funds Office for additional claims review. |
| Preauthorization for Specialty Pharmaceuticals and Certain Additional Drugs<br><br>Contact Express Scripts at (800) 753-2851 for preauthorization. | The plan will pay for FDA-approved specialty pharmaceuticals that meet the Plan's medical policy criteria for treatment of the condition. The prescribing physician must contact the Fund's pharmacy benefit manager (PBM) to request prior authorization of the drug(s). If preauthorization is not sought, the Plan will deny the claim and all charges will be the participant's responsibility. Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. The Plan in conjunction with its advisors and service providers determines which specific drugs are payable. This may include medications to treat hepatitis C, cystic fibrosis, rheumatoid arthritis, multiple sclerosis, and many other diseases, as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin. |

| | |
|---|---|
| | Express Scripts has also identified certain additional drugs that require preauthorization. These drugs have therapeutic equivalents with the same clinical efficacy that are available for a lower cost. |
| ***Medicare Supplement*** | |
| Medicare Part A & B Benefits | You are covered for any service approved by Medicare, Including Part A & B deductibles, up to the Provider reimbursement provided by Medicare. |
| ***TELEMEDICINE SERVICES*** | |
| Telephone, online, or video conference with Physician | $0 Copay and Covered at 100% with no deductible |

| ***HEARING BENEFITS*** | |
|---|---|
| Audiometric exam – once every 36 months | Covered up to 100% of usual, customary and reasonable fee. |
| Hearing aids – once every 36 months | Up to $800 per ear (No dollar limit for dependent children) |

| ***PRESCRIPTION DRUG BENEFITS ADMINISTERED BY EXPRESS SCRIPTS*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Prior authorization | Preauthorization must be obtained for specialty drugs. Certain additional drugs that have therapeutic equivalents for lower cost also require prior authorization. | |
| Days' supply limits | Up to 30, 60 or 90-day supply for non-specialty drugs. 30 days for specialty drugs. | |
| Preventive services as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by the Plan that are in compliance with the provisions of the Patient Protection and Affordable Care Act including, but not limited to:<br>- Aspirin to prevent cardiovascular disease<br>- Breast cancer prevention drugs<br>- Iron supplementation in children<br>- Oral fluorides for children<br>- Tobacco cessation (one 180-day course or treatment per year)<br>- Routine vaccinations for children & adults<br>- Effective 12/1/2017 certain low to moderate dosage statins for those age 40 to 75 | Covered 100%; no copay | Not covered |
| Contraceptives including:<br>Oral, transdermal, vaginal, IUD, implant, and diaphragms | Covered 100%; no copay | Not covered |
| Copays* up to the copay reduction maximum ($500) per Medicare-eligible individual or non-Medicare Dependent(s).<br>One copay per 30-day supply. | $10 generic, $30 brand, $50 non-preferred brand or specialty | $10 generic, $30 brand, $50 non-preferred brand or specialty; participants will have to submit a claim for reimbursement when using a non-network pharmacy |
| Copays* after the copay reduction maximum ($500) per Medicare- | $0 generic, $10 brand, $25 non-preferred brand or | $0 generic, $10 brand, $25 non-preferred brand or |

| | | |
|---|---|---|
| eligible individual or non-Medicare Dependent(s).<br>One copay per 30-day supply. | specialty | specialty; participants will have to submit a claim for reimbursement when using a non-network pharmacy |

*Kroger pharmacies will discount all co-payments by one dollar ($1) and will allow ninety (90) day drug supplies.

| ***DENTAL 250 BENEFITS ADMINISTERED BY DELTA DENTAL*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network Reimbursement** |
| Calendar year Deductible | $25 per individual | The Plan contracts with the Delta Dental PPO and Premier networks. There is not a requirement to use the Delta Dental networks, but there may be a financial advantage in doing so. When obtaining services from a Delta Dental provider the participant is assured the Plan's payment for covered services along with any participant fee responsibilities (deductibles or coinsurance) will be accepted by the Delta Dental provider as full payment. |
| Calendar year maximum benefit | $250 per individual | |
| Preventive Services (exam and cleaning) | Covered at 100%, no deductible | |
| Diagnostic Services (x-rays) | 85% after deductible | |

| ***VISION BENEFITS ADMINISTERED BY VSP*** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network Reimbursement** |
| Adult Eye exam – once every 24 months<br>Dependent Child – once every 12 months | $10 copay | Plan pays up to $35 per visit |
| Adult Prescription lenses – once every 24 months<br>Dependent Child Prescription Lenses – once every 12 months | Single vision, Lined Bifocal, Lined Trifocal and Polycarbonate lenses for dependent children: $25 copay; additional copays apply for optional lenses:<br>Standard Progressive Lenses: $50<br>Premium Progressive Lenses: $80-90<br>Custom Progressive Lenses: $120-160<br>Avg. 35-40% off lens options. | Single vision up to $25<br>Bifocal lenses up to $40<br>Trifocal lenses up to $55<br>Lenticular lenses up to $80 |
| Adult Frames – once every 24 months if frame is obtained in-network, no out-of-pocket expenses other than the copayment will apply. The wholesale cost of the frame cannot exceed the Wholesale Network Frame Allowance. Same rules apply for Dependent Child | Frame allowance $170; 20% off amount over your allowance | Frame benefit $45<br>Frame allowance N/A |

| | | |
|---|---|---|
| Frames, but benefit allows for frames every 12 months | | |
| Adult Contact lenses – once every 24 months<br>Dependent Child Contact lenses – once every 12 months – can be chosen in lieu of lenses and frames | Medically necessary: 100%<br>Elective: up to $120 Allowance; 15% off contact lens exam (fitting and evaluation) | Medically necessary: up to $210<br>Elective: up to $105 |
| Low Vision Benefit - available to participants with severe visual problems not correctable with regular lenses. (Maximum benefit $1,000 per participant every two years) | Supplementary testing covered in full; supplemental care aids covered at 75% of cost | Supplementary testing covered up to $125: supplemental care aids covered at 75% of cost. |
| Additional Coverage, Savings and Discounts | Diabetic Eyecare Program, 30% off additional glasses and sunglasses. 20% off VSP doctor within 12 months of your last Well Vision Exam, guaranteed pricing on retinal screening, discounts on Laser Vision Correction. | |

| ***OPT OUT BENEFIT*** | |
|---|---|
| Normal Retirees with Dental and Vision | Participants with other coverage may opt out of the medical and prescription plans without forfeiting re-entry rights. Participants may re-enter the plan if they experience a qualifying life event that leads to a loss of their alternate coverage.<br><br>Benefits retained when you opt out:<br>Vision, Dental, EAP, Death Benefit |
| Surviving Spouses with Dental and Vision | Participants with other coverage may opt out of the medical and prescription plans without forfeiting re-entry rights. Participants may re-enter the plan if they experience a qualifying life event that leads to a loss of their alternate coverage.<br><br>Benefits retained when you opt out:<br>Vision, Dental, EAP |

## VII. COMPREHENSIVE MEDICAL BENEFITS

| Eligible Employee Classification | Eligible for Medical Benefits |
|---|---|
| Active Employees/Eligible Dependents | Yes |
| Class Twenty-Six Employees/Eligible Dependents | Yes |
| Indentured Apprentice/Eligible Dependents | Yes |
| Early Retiree/Eligible Dependents | Yes |
| Normal Retiree/Eligible Dependents | Yes |
| Totally and Permanently Disabled Employees/Eligible Dependents | Yes |
| Surviving Spouse/Surviving Eligible Dependent | Yes |
| Residential Trainees (Divisions A and B) | No |
| Residential Trainees (Divisions C and D) | Base Only |
| Teledata Employees (Divisions 1 and 2) | Base Only |
| Teledata Employees (Divisions 2 – 6) | Yes |

***For Purposes of this Section:***

- Hospital shall mean any hospital institution that is accredited by the Joint Commission on Accreditation of Hospitals, accredited by the American Joint Commission on Accreditation of Hospitals, accredited by the American Osteopathic Association, or accepted by the Social Security Administration for participation in the Medicare reimbursement program in accordance with 42 U.S.C. Section 1395bb. Hospitalization shall mean admission to a hospital.
- Board and room in semi-private accommodations, as well as semi-private intensive and coronary units, or board and room in a private room if determined to be Medically Necessary. Determination that hospitalization is Medically Necessary is valid only if it is made by the attending physician and the Utilization Review Agent contracted by the Plan at time of hospitalization, or confirmed by Utilization Review Agent within 48 hours in the event of emergency or urgent medical conditions requiring isolation.
- Covered expenses include those associated with hospitalization, including anesthesia, for necessary services and supplies other than room and board. Also, includes the administration of anesthetics, other than local infiltration anesthetics.
- Approval by the Utilization Review Agent must be obtained in order to document the Medical Necessity of in-hospital treatment as opposed to outpatient treatment.
- Participants (other than those eligible for Medicare) must obtain certification for hospitalization from any Utilization Review Agent with which the Plan contracts at the time of hospitalization. Absent a medical emergency, this certification must be obtained before the Participant is admitted. In the event that a medical emergency exists, certification must be obtained within 48 hours of the Participant's admission to the hospital.
- To the extent that a Participant fails to obtain certification for a hospitalization, a penalty will be imposed by reducing coverage for board and room charges and miscellaneous charges to 80% of coverage otherwise available. This penalty is in addition to any copayment or co-insurance provisions. The penalty does not count toward any out-of-pocket amount.

**Covered Hospital Expenses (inpatient)**

- Includes medical care, services, and supplies.

**Covered Services by Intensive Care Unit, Cardiac Care Unit, or Burn Unit**

- Services are subject to 20% penalty for failure to obtain advance approval from the Utilization Review Agent.

**Covered Diagnostic Services, Laboratory, X-ray, and Pathology**

- Services covered include:
    a) Angiography.
    b) All Biopsies.
    c) Ultrasounds.
    d) C.A.T. Scans.
    e) MRI and MRA.

**Covered Surgical Expenses**

- Includes surgery and anesthesia charges made by a physician for surgical care and for the administration of anesthesia.
- Additional charges for services rendered by additional physician or surgeons assisting the primary physician or surgeon may not exceed 1/3 the cost of the primary physician.
- Services include:
    a) Tonsillectomy and/or Adenoidectomy.
    b) Breast Surgery.
    c) Caesarean Section (planned).
    d) Foot Surgery.
    e) Gall Bladder Surgery.
    f) Heart Surgery.
    g) Hysterectomy.
    h) Joint Replacement Surgery.
    i) Joint Surgery.
    j) Laminectomy.
    k) Nasal Surgery.
    l) Prostatectomy.
    m) Spinal Fusion.
    n) Surgical Treatment of Jaw disorder.
    o) Surgery and anesthesia charges made by a physician for surgical care and for the administration of anesthesia.
    p) Additional charges for services rendered by additional physicians or surgeons assisting the primary physician or surgeon not to exceed 1/3 the cost of the primary physician.

    **Note:** The Utilization Review Agent will determine if a second surgical opinion is necessary.
- **Oral Surgery**: In-hospital expenses associated with oral surgery are covered, provided the Eligible Employee submits documentation supporting the fact it was a medical necessity that the procedures be performed in a hospital, or the Eligible Employee obtains hospital pre-certification from the Utilization Review Agent with which the Plan has contracted at the time of hospitalization.

**Covered Physician Charges (not related to mental health/substance abuse)**

- Services include:
    a) Inpatient.

b) Office visits.
c) Specialist Office Visits.
d) Treatment and diagnosis of infertility of Active Employees and Spouses only.

**Note:** Additional charges for services rendered by additional physicians or surgeons assisting the primary Physician or surgeon may not exceed 1/3 the cost of the primary Physician.

**Therapy Services**:

a) Chemotherapy.
b) Radiation/Radio Therapy.
c) Physical Therapy (after 18 visits).
d) Occupational Therapy (after 18 visits).
e) Dialysis.
f) Respiratory Therapy.
g) Pulmonary Therapy.
h) Hyperbaric Therapy.
i) Speech Therapy (after 18 visits).
j) Insulin Therapy.
k) Vision Therapy.
l) Cardiac Therapy.

**Note:** Please refer to Outpatient Dialysis Claims information at the end of this Schedule.

**Covered Urgent and Emergency Medical Care**

- **Emergency Room**:
  a) Accident and Acute medical emergencies incurred in an Emergency Room of a hospital or licensed urgent care clinic provided that if an Participant is admitted to a hospital, the Utilization Review Agent is notified within 49 hours of admittance.
  b) Accidents – Emergency services for accidental injuries are covered provided that services are rendered within 48 hours after the accident and services are rendered by a legally qualified surgeon or physician in an accredited hospital or clinic.
  c) Acute Medical Emergencies – Emergency treatment is covered if the condition results from the admission of the Participant to a hospital within 24 hours or sudden and/or serious symptoms which constitute a threat to the patient's physical or psychological well-being requiring immediate medical attention to prevent possible permanent impairment or loss of life.
  d) An injury by accident includes any injury caused by an external or violent or accidental reason and is non-occupational in nature.
  e) A co-payment is due for Emergency Room Charges. Co-payment is waived if the Participant is admitted to the Hospital from the Emergency Room.

- **Ambulance/Transportation**:
  a) Transportation of a Participant within the U.S. and Canada by railroad, by a regularly scheduled flight of a commercial aircraft, or by helicopter from the place at which an injury or sickness occurred to (but not back from) a hospital equipped to furnish special treatment related to such disability
  b) Local professional ambulance service for transportation of an Participant to a hospital.
  c) Out-of-Network charges for Ambulance services is paid at 75% of billed charges.

- **Urgent Care**:
    a) Urgent care as defined by the Urgent Care Association of America as medically necessary services that are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours.

**Covered Preventive Services (All Participants)**

- In general, the following services will also be covered without regard to any Deductible, Copayment, or Coinsurance requirements that would otherwise apply:
    a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Tax Force.
    b) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Participant involved.
    c) With respect to Eligible Dependents who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration;
    d) With respect to Participants who are women, such additional preventive care and screenings not described above in this section, but as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Preventive Care: Medical Necessity determinations are not required to access preventive care services.
- Health Maintenance Exams: Includes chest x-ray, EKG, cholesterol screening including other select lab procedures.
- Immunizations: Preventive immunizations prescribed and administered by medical professional licensed to administer such immunizations. Immunizations are covered per sub-bullet "b" above, to include but not limited to flu shots, and immunization injections for the prevention of diphtheria, hepatitis (A, B, A&B, b), herpes zoster (shingles), human papillomavirus (HPV), MMR (measles, mumps, rubella, individually or separately), meningococcal, pertussis, pneumococcal, polio, rotavirus, tetanus, and varicella (chicken pox). In addition, the Plan covers non-routine vaccines for conditions such as rabies, yellow fever, Japanese encephalitis, typhoid, and anthrax.
- Alcohol misuse counseling: Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.

- **Adult's Covered Preventive Services**
    a) Blood pressure screening in adults: Screening for high blood pressure in adults aged 18 and older.
    b) Colorectal cancer screening: Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years. Covered services include medically indicated sedation or anesthesia, pathology, and medically appropriate pre-screening specialist consultation.
    c) Depression screening for adults: Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.

d) Diabetes screening: Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
e) Healthy diet counseling: Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
f) Obesity screening and counseling for adults: Screening for obesity and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Coverage includes up to 26 face-to-face behavioral counseling sessions with a doctor (MD or DO) or a behavioral therapist specializing in weight loss. Coverage is for one course of treatment per year.
g) Tobacco use counseling and interventions for non-pregnant adults: Tobacco cessation interventions for those who use tobacco products.
h) Syphilis screening for non-pregnant persons: Screening of persons at increased risk for syphilis infection.
i) Hepatitis C and Tuberculosis (TB) screenings: Screening available for adults at high risk for these conditions.
j) Lung cancer screening with low-dose CT for ages 55+, where there is a history of smoking, available once per calendar year.

- **Men's Covered Preventive Services**
  a) Abdominal aortic aneurysm screening for men: One-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
  b) Cholesterol abnormalities screening for men 35 and older: Screening for men aged 35 and older for lipid disorders.
  c) Cholesterol abnormalities screening for men younger than 35: Screening for men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.

- **Women's Covered Preventive Services**
  a) BRCA (Breast Cancer) screening, counseling: Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.
  b) Breast cancer preventive medication: Clinical consultation to discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
  c) Breast cancer screening: Screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.
  d) Cervical cancer screening: Screening for cervical cancer in women who have been sexually active and have a cervix.
  e) Chlamydial infection screening for non-pregnant women: Screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
  f) Gonorrhea screening for women: Screening for all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
  g) HPV DNA testing for women available every 3 years starting at age 30.

- **Pregnant Women's Covered Preventive Services**
  a) Routine prenatal office visits are a covered benefit.
  b) Anemia screening for pregnant women: Routine screening for iron deficiency anemia in asymptomatic pregnant women.
  c) Bacteriuria screening for pregnant women: Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
  d) Breastfeeding counseling: Interventions during pregnancy and after birth to promote and support breastfeeding.
  e) Chlamydial infection screening for pregnant women: Screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
  f) Hepatitis B screening for pregnant women: Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
  g) Osteoporosis screening for women: Screening for women age 65 or older for osteoporosis. for women at increased risk for osteoporotic fractures routine screening begin at age 60.
  h) First Pregnancy Rh incompatibility screening: Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
  i) Rh incompatibility screening 24-28 weeks' gestation: Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
  j) Tobacco use counseling for pregnant women: Augmented, pregnancy-tailored counseling to those who smoke.
  k) Syphilis screening for pregnant women: Screening of pregnant women for syphilis infection.

- **Adult & Adolescent's Covered Preventive Services**
  a) HIV screening: Screening for human immunodeficiency virus (HIV) for adolescents and adults at increased risk for HIV infection.
  b) STIs counseling: High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.

- **Adolescent's Covered Preventive Services**
  a) Depression screening for adolescents: Screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.

- **Children & Infants Covered Preventive Services**
  a) Well Baby Care: Limited frequency in accordance with guidelines that are compliant with the provisions of the Patient Protection and Affordable Care Act.
  b) Gonorrhea prophylactic medication for newborns: Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
  c) Hearing loss screening for newborns: Screening for hearing loss in all newborn infants.
  d) Hypothyroidism screening for newborns: Screening for congenital hypothyroidism in newborns.

e) Obesity screening and counseling for children: Screening children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
f) PKU screening for newborns: Screening for phenylketonuria (PKU) in newborns.
g) Visual acuity screening in children: Screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.

**Covered Alternatives to Hospital Care**

- Skilled Nursing: One or more of the professional services that may be rendered by a professional nurse or by a licensed practical nurse under the direction of a registered professional nurse.
- Hospice: Participant must obtain advance approval or a treatment Plan from a Utilization Review Agent. The approved hospice care treatment is exclusive of, and in lieu of, all other Medical Benefits under the Plan.
- Rehabilitation or Convalescent Facility - Facility must be:
    a) Primarily engaged in and licensed to provide skilled nursing and physical restoration services for patients convalescing from an injury or disease on an inpatient basis for a fee;
    b) Under the full-time supervision of a physician or registered professional nurse;
    c) Provides skill nursing services on a 24 hour basis under the direction of a full-time registered professional nurse, with licensed nursing personnel on duty at all times;
    d) Maintains a complete medical record on each patient;
    e) Has in effect a utilization review plan for each patient; and
    f) Does not include any institution, or part thereof, which is used principally as a place of rest, a place of custodial care, a place for educational care, a place for care of mental conditions (including drug or alcohol addiction, mental retardation, or elderly).

**Human Organ Transplants**

- Organ & Tissue Transplants:
    a) Organ transplant services and partial organ transplant services provided the Participant obtains prior approval of the Utilization Review Agent. The first notification must occur at the time the patient presents to the facility to begin the initial transplant qualification process (i.e., Phase I or Pre-transplant evaluation visit).
    b) It is the patient and/or referring physician facility's responsibility to notify the Utilization Review Agent at the time the clinical indication for organ transplantation is identified and confirmed.
    c) Covered organ transplants for adults and children include both solid organ and bone marrow/stem cell procedures as follows: heart, lung (single and double), heart with lung, liver, kidney, cornea, pancreas, kidney with pancreas, allogenic bone marrow and autologous bone marrow.
    d) Eligible charges include cadaveric and live donor whole organs. All transplants are subject to established guidelines for determining experimental procedures and investigational procedures versus standard practice.

**Other Covered Services**

- Durable Medical Equipment:
    a) Medical Equipment charges and hospital type equipment made by a person or institution, for oxygen or rental or purchase, as approved by the Utilization

Review Agent, of equipment for administration of oxygen, wheelchair or hospital-type bed, or equipment required for the treatment of respiratory problems.
b) Pre-Authorization required for equipment in excess of $1,500.
c) Subject to 20% penalty for failure to obtain advance approval from Utilization Review Agent.

- Treatment of Jaw Disorders – Temporomandibular Joint Dysfunction (TMJ) and Bruxism
  a) No authorization required.

- Chiropractic and Acupuncture:
  a) 18 visits per year without pre-approval by Utilization Review Agent, then all subsequent visits must be pre-authorized.
  b) Plan shall not be obligated to pay for Eligible Charges if Participant fails to obtain advance approval from Utilization Review Agent.

- Home Health Care:
  a) Plan shall not be obligated to pay for Eligible Charges if Participant fails to obtain advance approval from Utilization Review Agent.

- Private Duty Nursing - If medically necessary.

- Orthotics and Prosthetics:
  a) Purchase of braces for a permanent impairment, orthotics, and orthopedic shoes if in conjunction with leg braces covered hereunder.
  b) For artificial limbs or eyes for the replacement of natural limbs or eyes.

- Lasik Eye Surgery, Active Employee Only:
  a) Charges incurred for a Corrective Vision Procedure (as defined below) of up to $500 per eye. Reimbursements shall be limited to one procedure per eye and per lifetime.
  b) For this purpose, a "Corrective Vision Procedure" means laser-assisted in-situ keratomileusis (commonly known as "LASIK"), photorefractive keratectomy (commonly known as "PRK"), radial keratotomy (commonly known as "RK"), or other form of laser or laser-assisted vision corrective eye surgery approved by the Food and Drug Administration and performed by a licensed ophthalmologist for the purpose of correcting nearsightedness.

**Autism Spectrum Disorders, Diagnosis and Treatment**

- Therapy and Treatment for Pervasive Developmental Disorders or Autism Spectrum Disorder not otherwise covered under the Plan:
  a) Annual benefit of up to $4,500 for treatment and therapy prescribed by a licensed board-certified psychiatrist or a board-certified neurologist for a diagnosis of Pervasive Developmental Disorder or Autism Spectrum Disorder not otherwise covered under the Plan. This benefit is only applicable in instances where the Participant is 12 years of age or younger and obtains advance approval from the Utilization Review Agent.
  b) For the purposes of this Eligible Charge, Pervasive Developmental Disorder or Autism Spectrum Disorder shall refer exclusively to those covered individuals with a documented history of a disorder as defined in the DSM-IV or the currently recognized successor counterpart coding. This class of disorders are often favorably impacted through early intervention and share the following

characteristics: impairments in social interaction, imaginative activity, verbal and nonverbal communication skills, and a limited number of interests and activities that tend to be repetitive, including Autistic Disorder or Autism, Rett's Disorder or Syndrome, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (also known as PDDNOS or PDD).

**Maternity Services**

- Maternity (Dependent children are excluded from maternity coverage):
    a) Maternity benefits are not to be limited for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain prior authorization for prescribing a length of stay not in excess of the above periods.

**Infertility**:

- Treatment for infertility is only available to Active Employees and Spouses.
- Involuntary infertility will be considered a disease, and the diagnostic tests performed to determine the cause of infertility will be a payable expense as provided by the schedule of benefits under diagnostic x-ray and laboratory, and major medical. In addition, treatment by a physician will be payable under the major-medical portion of the Plan.
- The reversal of a vasectomy or tubal ligation is not a payable expense of the Plan.
- Artificial insemination and in-vitro fertilization (test tube) are not payable expenses of the plan.

**Other Important Information**

- Exclusion of Injury or Illness Incurred or Aggravated in Uniformed Services. Notwithstanding any in this Plan to the contrary, should an Participant have his eligibility for coverage under the Plan terminate, and thereafter have coverage reinstated, Benefits shall not be payable for treatment or services rendered for any illness or injury determined by the United States Secretary of Veterans' Affairs to be incurred in, or aggravated during, performance of service in the Uniformed Services.
- Utilization of Health Care. The Benefits provided pursuant to this Plan are limited to the usual, customary and reasonable charges and appropriate health care service performed within commonly accepted practices as determined by the Utilization Review Agent or any other reimbursement specified, directed or adopted by the Board of Trustees. Consistent with the procedures for Claims for Benefits set forth in Claims and Appeals, the Plan pays a schedule of Benefits and does not approve, deny or determine the course of treatment decided by and between a patient and his physician.
- Notwithstanding anything to the contrary in this Schedule, Medical Benefits shall be paid in amounts greater (or lesser) than 80% or 60% of the reimbursement amount in the case of charges for services rendered by health care providers as may be designated by the Board of Trustees from time to time, in which case the reimbursement amount will be determined in accordance with the terms and conditions set forth in written notices thereof provided by the Administrative Manager to Participants.
- Outpatient Dialysis Claims –
  The Trustees have determined that it is in the best interests of the Plan and its Participants to discontinue in-network dialysis coverage, due to

a) The concentration of dialysis providers in the Northwest Ohio and Southeast Michigan market, which may allow these providers to exercise control over prices for dialysis-related products and services;
b) The potential for discrimination by dialysis providers against non-governmental and non-commercial health plans such as the Plan, which may lead to increased charges for dialysis-related products and services;
c) Significant inflation of the prices charged to participants of non-governmental and non-commercial health plans, such as the Plan, by dialysis providers to subsidize reduced prices to other types of payers as incentives; and
d) The Trustees' fiduciary obligation to preserve Plan assets against charges which exceed reasonable value and which are used for purposes contrary to Plan Participants' interest.

The Plan has contracted a third-party, called Renalogic, to manage the provision of dialysis services, and has adopted the following program for outpatient dialysis claims. This program shall apply to all claims for reimbursement of products and services for outpatient dialysis regardless of the condition causing the need for treatment.

The program shall apply to all such claims received on or after October 1, 2016, regardless of when the first claim for such products or services was received with respect to the Participant.

All such claims will be subject to cost review to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination, Renalogic shall consider factors including:

a) Market concentration – Renalogic shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
b) Discrimination in charges – Renalogic shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

In the event that a charge indicates a reasonable probability that the above factors likely increased the charges for outpatient dialysis, Renalogic may, in their discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, Renalogic may subject the claims, and all future claims from that provider with respect to the participant, to the following payment limitations, under the following conditions:

a) Where Renalogic deems it appropriate in order to minimize disruption and administrative burdens for the Participants, claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
b) Where the provider is, or has been a participating provider under a Preferred Provider Organization available to Plan participants, upon Renalogic's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this section.
c) The maximum benefit payable for claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

d) Renalogic shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies, by all types of plans in the applicable market during the preceding calendar years, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. Renalogic may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

e) The Participant, or where the right to benefits has been properly assigned, the provider, may provide information with respect to the reasonable value of the supplies and/or services for which payment is claimed, on appeal of the denial of any claim or claims. In the event Renalogic determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, Renalogic shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by Renalogic, based upon credible information from identified sources. Renalogic may, but is not required to, review additional information from 3rd party sources in making this determination.

f) All charges must be billed in accordance with generally accepted industry standards.

Where appropriate, and where a willing provider acceptable to the Participant is available, Renalogic may enter into an agreement establishing the rates payable for outpatient dialysis with such provider, so long as such agreement identifies this provision and clearly states that it is intended to supersede it.

Renalogic shall have full authority and discretion to interpret, administer, and apply this provision, to the greatest extent permitted by law.

- Secondary Coverage – Plan beneficiaries who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the beneficiary incurring costs which are not covered by the Plan, which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.
- General Plan Administration – The Plan Administrator shall administer this Plan in accordance with its terms and established policies, interpretations, practices, and procedures**.** It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participants rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator shall be final and binding on all interested parties. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Participant is entitled to them.

## VIII. GENERAL EXCLUSIONS AND LIMITATIONS

The Plan contains certain general exclusions and limitations. However, the Plan will not deny benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or a health condition (including both physical and mental health conditions). For example, the Plan would not deny coverage for a suicide attempt or other self-inflicted injury caused by depression.

Please note: The Wal-Mart and Sam's Club Pharmacies are specifically excluded from the Plan's network of pharmacy providers. Any prescription filled at a Wal-Mart or Sam's Club Pharmacy will not be eligible for coverage under the Plan. This exclusion does not apply to Plan M.

Limitations on Hospitalization

Eligible Charges for hospitalization are limited by the following conditions:

- The Participant is admitted to the hospital by a physician or licensed dentist and is hospitalized;
- Miscellaneous charges are Eligible Charges only if they are incurred during a period for which benefits are payable for board and room charges. This requirement will be waived if treatment is given in a hospital and the only hospital charge is for services and supplies rendered in connection with and on the same day as a surgical procedure;
- Hospitalization must commence while the Participant is eligible for Medical Benefit;
- If the Participant would be eligible for hospitalization and treatment at any hospital operated by the United States of America, or any agency, department or until thereof (hereinafter referred to as a "government hospital") but elects to be hospitalized and treated at any nongovernmental hospital for any reason other than Medical Necessity directed by his attending physician or consulting physician thereto, the Eligible Charges hereunder shall be limited to the amount in excess of those charges and expenses which would have been provided and/or paid for by the government hospital or government agency operating the same;
- In-hospital room and miscellaneous expenses are covered for services that could not otherwise be as well provided in an outpatient setting;
- All forms of bariatric surgery are excluded from coverage;
- Treatment of sexual dysfunction is not covered unless Medically Necessary, as determined by the case management consultant;
- Genetic testing services are excluded under this Plan except for amniocentesis during pregnancy and BRCA testing and counseling when there is a family history of breast or cervical cancer; and
- Coverage for counseling or testing concerning inherited (genetic) disorders is excluded from coverage. This exclusion does NOT apply to BRCA screening and counseling or when services are *medically necessary* as stated by a physician during the course of a high-risk pregnancy.

General Exclusions and Limitations

Subject to the above, in addition to exclusions and exceptions set forth elsewhere in this Plan and except as specifically provided elsewhere in this Plan, Benefits shall not be payable for treatment or services rendered:

- For confinement, surgery, or medical care or service during confinement within any facility operated by, or under contract with, a governmental authority, or hospitalization,

medical, or surgical treatment provided or paid for by any governmental agency, other than service in a Veteran's facility for non-service related illness or injury and as otherwise required by applicable law, and unless a charge is made which the Eligible Employee is required to pay;

- While the Participant is in active duty of any Uniformed Service, including, but not limited to; the United States Army, the United States Navy, the United States Air Force, the United States Marines, National Guard or other military service;
- In connection with injury or sickness resulting from active duty of any uniformed service, any act or accident of war, whether declared or undeclared, insurrection, or any atomic explosion or other release of nuclear energy (except only when being used solely in medical treatment) whether in peacetime or wartime and whether accidental or intentional;
- In the office or place of business of the Participant's employer, or in a medical department, clinic, or similar facility provided or maintained by that employer;
- For surgery or affiliated charges for cosmetic or beautifying purposes except for the prompt repair of a non-occupational injury, or as otherwise provided herein;
- For treatment or services covered by Workers' Compensation or any similar legislation, Medicare, or any government law, provision, or agency;
- For convalescent, rehabilitative, or rest home charges, except as provided by the Board of Trustees;
- For private duty nurses' services except as provided under herein;
- For the reversal of a vasectomy and/or related charges and for the reversal of a tubal ligation and/or related charges;
- Alternative, complementary or other non-standard treatments, therapies or services including, but not limited to, acupressure, aversion therapy, hair analysis, herbal treatments, holistic treatment, homeopathy, hypnosis, meditation, mind-body stress management, naprapathy, naturopathy, nutritional counseling (unless an exception is specifically stated), relaxation therapy, soft-tissue manipulative therapy; or yoga;
- For artificial insemination and in-vitro fertilization (test tube) and/or related charges except as provided herein;
- On account of any injury incurred or sickness contracted, a contributing cause of which was the injured or sick person's commission of or attempt to commit a crime, or a contributing cause of which was the injured or sick person's engagement in an illegal occupation;
- For care, services, supplies, devices, drugs, or procedures which are not considered normally accepted medical treatment, or which are experimental or research in nature, except as required by applicable law;
- Charges caused by a disease which is an occupational disease or any injury which is an occupational injury;
- Charges for tests, treatment, services or supplies not recommended and approved by a physician, and charges or services and supplies which are not necessary for diagnosis or treatment of the disease or injury concerned;
- Charges which are unreasonable, would not have been made if no Plan coverage existed, or which Participants are not legally obliged to pay;
- For maternity expenses for an Eligible Dependent of an Participant, except for maternity expenses provided herein for Spouse of an Eligible Employee otherwise provided under the terms of the Plan and certain women's preventive services related to pregnancy and childbirth as required by applicable law;

- Expenses associated with any and all diet control, not including anti-obesity medication prescribed by a physician and certain screening and counseling related to obesity as required by applicable law;
- Charges for expenses not deemed to be Medically Necessary;
- Charges for failure to keep an appointment;
- Charges for services not performed within the scope of the provider's or Health Care Professional's license;
- Charges for artificially terminated pregnancies of Dependent Children, except when the life of the mother would be in danger if he or she carried the fetus to term, not including medical complications which arise from an artificially terminated pregnancy and charges incurred from miscarriage or an incomplete or a missed miscarriage;
- Charges incurred for services or supplies which constitute personal expenses, such as televisions or telephone use, or charges in connection with hospitalization or expenses actually incurred by other persons;
- Charges for the following:
    - Physical examinations or services required by an insurance company to obtain insurance;
    - Physical examinations or services required by a governmental agency such as the Federal Aviation Administration and Department of Transportation;
    - Physical examinations or services required by an employer in order to begin or continue working;
    - Premarital examinations;
    - Screening examinations, except as specified; or
    - Routine or annual physical examinations, except as specified.
- Charges for services rendered by a physician or other Health Care Professional who is a close relative of the Participant, or resides in the same household as the Participant;
- Charges incurred outside the United States if the Participant traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies not available within the United States;
- Charges for inpatient confinement primarily for X-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an active illness or injury, unless otherwise provided under any preventive care covered under this Plan;
- Charges incurred for educational, vocational or training purposes, except for 3 sessions of diabetic counseling;
- Charges for arch supports and other foot care or foot support devices only to improve comfort or appearance which include, but are not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails;
- Charges for the treatment of conditions related to an autistic disease of childhood, learning disabilities, hyperkinetic syndromes, behavioral problems or mental, retardation, except as otherwise specified herein;
- Charges for telephone consultations, except as provided for under any online or telemedicine service provided by the Plan;
- Charges for completion of claim forms or copies of medical records;
- For fraudulent or misrepresented claims;
- Obesity Treatment:
    - Charges for any surgery or procedure primarily for obesity, or for the care and treatment of obesity, weight loss, or dietary control, regardless of whether such weight loss treatment has been included in the treatment plan for a separate

medical condition aggravated by obesity (such procedures are collectively referred to as "Obesity Treatment"). Procedures that constitute Obesity Treatment include, but are not limited to, gastric bypass, gastric stapling, intestinal bypass, lipectomy, suction lipectomy, panniculectomy, laproscopic band surgery, and any other surgical procedure, a purpose and result of which is primarily to remove adipose tissue, as well as all weight loss reversal procedures;
    - Charges for the treatment of any medical condition resulting from or arising out of Obesity Treatment;
    - Notwithstanding the above, screening and counselling for obesity are covered as preventive health services as required by applicable law;
- Charges for the treatment of any medical condition following the unauthorized discharge from confinement at a hospital or other treatment facility to which the Eligible Employee had been admitted for the treatment of such illness or condition;
- Except as set forth elsewhere in this Plan, habilitation is not a covered benefit;
- Charges for sex change or sex/gender reassignment surgery, as well as service and procedures related to being transgender, gender change, transsexualism, gender identity disorder, and gender identity dysphoria;
- Charges for household items or modifications to the Participant's home related to a medical diagnosis;
- Charges related to marijuana, medical marijuana, CBD products, THC products, or any other reasonable interpretation of "related to marijuana" as set forth by the Administrative Manager or the Trustees;
- Lost, missing, or damaged devices, Durable Medical Equipment, or otherwise;
- Fitness expenses, including, but not limited to, health club memberships, workout or exercise equipment, personal fitness or athletic trainers, and spas or saunas, even if recommended by a doctor;
- Home health, first aid products and other household items purchased over-the-counter or off-the-shelf, whether or not recommended by a physician. This exclusion applies to, but is not limited to:

| | | |
|---|---|---|
| Bandages | Home diagnostic kits | Scales |
| Batteries (except Hearing Aid batteries as set for the in that section) | Hypodermic needles/ syringes (except diabetic supplies) | Sleep aids |
| Blankets | Incontinence aids | Support garments |
| Blood pressure testers | Light boxes | Stethoscopes |
| Cords | Mattresses/covers | Thermometers |
| Digestive aids | Neck/back braces | Vibratory equipment |
| Emergency alert devices | Non-prescription medications (except as specified herein) | |
| Eye-care products | Pillows | |

- Personal development programs such as wilderness programs, therapeutic schools, camps, outdoor skills program, and aquatic or equine programs;
- Taxes or shipping and handling fees; and
- Surrogacy or surrogate fees, including but not limited to medical or other expenses for: (a) a surrogate who carries and delivers a child on behalf of a person covered under this Plan; or (b) a female who is covered under this Plan and who carries and delivers a child

that is not her child or that of her spouse. Any child born of a person who is covered under this Plan but acting as a surrogate for someone else will not be an Eligible Dependent of the surrogate mother or her spouse.

**Pre-Existing Condition Exception**. Per applicable law, pre-existing condition exclusions are no longer in force, and creditable coverage notices will no longer be produced.

**Utilization of Health Care**. The Benefits provided pursuant to this Plan are limited to (i) the usual, customary and reasonable charges, (ii) appropriate health care service performed within common, accepted practices, as determined by American Health Holdings, or other qualified reviewer, or (iii) any other reimbursement specified, directed or adopted by the Board of Trustees. Consistent with the procedures for Claims for Benefits set forth in Section XIV, the Plan pays a schedule of Benefits and does not approve, deny, or determine the course of treatment decided by and between a patient and his physician.

## IX. PRESCRIPTION DRUG BENEFITS

| Eligible Employee Classification | Eligible for Benefits |
|---|---|
| Active Employees/Eligible Dependents | Yes |
| Class Twenty-Six/Eligible Dependents | Yes |
| Indentured Apprentice/Eligible Dependents | Yes |
| Early Retiree/Eligible Dependents | Yes |
| Normal Retiree/Eligible Dependents | Yes |
| Totally and Permanently Disabled Employees/Eligible Dependents | Yes |
| Surviving Spouse/Eligible Dependent | Yes |
| Residential Trainees (Divisions A and B) | No |
| Residential Trainees (Divisions C and D) | Base Only |
| Teledata Employees (Divisions 1 and 2) | Base Only |
| Teledata Employees (Divisions 3 – 6) | Yes |

**NOTE**: Some of the limits described in this section do not apply to Plan M. Contact the Fund Office at 419-666-4450 if you are a Plan M Participant and have questions about your Prescription Drug Benefit.

**Prescription Drug Benefits Administered by Express Scripts**

a) Eligible Charges
   1) Eligible Charges for Prescription Drug Benefits include any prescription if state or federal laws require one for Participants to purchase a medication.
   2) Eligible Charges for Prescription Drug Benefits do not include any prescriptions filled at Wal-Mart or Sam's Club Pharmacies. No benefits are available for prescriptions purchased at Wal-Mart or Sam's Club Pharmacies. This exclusion does not apply to Plan M.

b) Timeliness of Claim
   1) Prescription Benefits are conditioned upon submission to the Fund Office no later than 24 months following the date the Eligible Charge is incurred.
   2) For information about appealing a denied claim, see the section entitled "Claims and Appeals Procedures."

c) Co-Payments
   1) If a Participant elects a brand name drug over a generic drug, he or she is responsible for the generic drug co-payment plus the difference in cost between the brand and generic drug, unless the Participant's physician has indicated that the Prescription should be filled "dispense as written."
   2) Participants shall make a co-payment to a Member Pharmacist for each prescription for up to a 30 day supply filled or refilled as provided in this paragraph. Subject to a maximum of $1,000.00 per family aggregate co-payments for a calendar year ($500 per Medicare eligible participant), the amount of the co-payment per prescription shall be as set forth in the Schedule of Benefits.
   3) After a family's co-payments have aggregated to $1,000.00 in a calendar year, the co-payment required for any prescription filled or refilled thereafter for each

Participant in that family until the close of the calendar year shall be in accordance with the Schedule of Benefits.

**Preventive Prescription Benefits Available at $0 Copayment**

a) Generic aspirin to prevent Cardio Vascular Disease for men: Use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
b) Generic aspirin to prevent Cardio Vascular Disease for women: Use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
c) Generic folic acid supplementation for women: A daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for women planning or capable of pregnancy.
d) Generic medications such as raloxifene and tamoxifen for breast cancer prevention in women who have a high risk.
e) Dental chemoprevention for preschool children: Oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride prescribed by their primary care physician.
f) Iron supplementation in children: Routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
g) Prescriptions for the following medications filled on or after 12/1/2017 will process for a $0 copay if you are between the ages of 40 and 75:
    - Atorvastatin 10mg and 20mg.
    - Fluvastatin 20mg, 40mg and Extended Release 80mg.
    - Lovastatin 10mg, 20mg and 40mg.
    - Pravastatin 10mg, 20mg, 40mg, and 80mg.
    - Rosuvastatin 5mg and 10mg.
    - Simvastatin 5mg, 10mg, 20mg and 40mg.
h) Tobacco cessation drug regimen: one, 180-day course of treatment per year, either prescription or over-the-counter.
i) FDA approved female contraceptives.
j) Bowel preparation treatments for colonoscopies.
k) Vaccines for conditions such as Hepatitis A, Hepatitis B, Hepatitis Zoster (shingles) (Shingrix for over age 50, Zostavax for over age 60), Haemophilus B, Human Papillomavirus (HPV), Influenza, Inactivated Poliovirus, Measles, Mumps, Rubella, Meningococcal, Pneumococcal (Prevnar 13 and Pneumovax 23), Tetanus, Diptheria, Pertussis, Rotavirus, Varicella, and non-routine vaccines for conditions such as rabies, yellow fever, Japanese encephalitis, typhoid, and anthrax.

**Quantity and Coverage Limits**

a) Covered drugs will be covered up to:
    - A 30 day supply for one copay.
    - A 60 day supply for two copays.
    - A 90 day supply for three copays.
b) The number of pills/doses for each prescription covered under a prescribed day supply varies based on the accepted clinical indication and will be determined by the Fund's Pharmacy Manager.
c) Some drugs may be limited to a quantity below those stated above if such quantity is not therapeutically indicated.
d) Specialty drugs are limited to a thirty day supply or less, as indicated.

e) A 30, 60 or 90-day supply for compounded prescriptions are covered up to $100 per 30-day supply. Compounds costing $100 or more require prior authorization (not applicable to Participants in Plan M). Participant must also make any applicable brand name copay.
f) Pain medications may be subject to quantity limits per Plan policy or state or federal law.
g) Some drugs may be subject to age limitations, for example, but not limited to, topical tretinoin such as Retin A.
h) Some quantity and coverage limits may not apply to Plan M. Contact the Fund Office if you are a Plan M Participant and have questions about your Prescription Drug Benefit.

**Refills**

a) Covered prescriptions can be refilled once you have consumed 75% of your monthly quantity limit. Your on-hand supply will be determined by the date of your last refill.

**Member and Non-Member Pharmacy**

a) The Plan shall designate Member and Non-Member Pharmacies from time to time.
b) To obtain coverage as an Eligible Charge, Participants must present their card on each visit to a Member Pharmacist.
c) If Participants are unable to use a Member Pharmacy, the Participant may obtain a prescription drug reimbursement form from the Fund Office; attach your receipt to the completed form and submit it to Express Scripts at the address on the form.
d) The Participant must pay the full amount of the prescription at purchase; you will then be reimbursed at the discounted network price minus the applicable copayment.

**Specialty Drugs (must obtain prior authorization)**

a) Specialty Drugs are medications meant to treat specific chronic disease states and genetic condition and include high cost drugs that frequently require special handling or administration. The drugs on the Specialty Drug List require clinical pre-authorization before they will be approved for coverage under your benefit plan. To obtain clinical prior authorization for a specialty drug, please call (800) 753-2851. If approved, your prescription supply will be limited to a thirty (30) day supply. Your prescription will be filed and sent to you via next day mail service. Specialty medications cannot be purchased through retail pharmacies. Specialty medications will only be dispensed through Accredo Specialty Pharmacy. The requirement to use only Accredo Specialty Pharmacy does not apply to Plan M.
b) To take advantage of the best prevailing reimbursement arrangement, the Fund can at its discretion, cover prescriptions administered in a facility, doctors office or home health setting as either a major medical or prescription benefit.
c) As determined by the Plan's pharmacy benefit manager from time to time, certain specialty pharmacy drugs are considered non-essential health benefits under the Plan. As such, the cost of such drugs shall not be applied towards the satisfaction of a participant's or dependent's out-of-pocket maximum under the Plan. The cost of such drugs will be reimbursed to the Plan by the drug's manufacturer at no cost to the participant. As such, copayments for certain specialty medications may be set to the maximum copayment tier of the current plan design, or any available manufacturer-funded copayment assistance. This change is effective November 1, 2019. If you have questions about this program, please contact the Fund Office.

**Prior Authorizations**

Prior Authorization (PA) assists in ensuring the appropriate usage of certain medications by applying FDA approved indications and manufacturer's guidelines to the utilization of certain medications. Express Scripts, the Plan's Pharmacy Provider, has identified those medications that have a high potential for serious side effects, high costs, or high abuse potential. Other types of prior authorizations include, but are not limited to, medications that exceed quantity limitations, age limitations, and/or require clinical determinations for appropriate utilization. Certain medications require prior authorization (approval before they will be covered). Express Scripts, in their capacity as pharmacy benefit manager, administers the clinical prior authorization process on behalf of the Plan.

Clinical Prior Authorization (CPA) can be initiated by the pharmacy, the Prescriber, or the covered person by calling toll free (800) 753-2851, 24 hours a day, 7 days a week.
To confirm whether you need prior authorization and/or to request a prior authorization form, call Express Scripts's Customer Service Call Center at (877) 797-9688 (for Plan M, (877) 788-5814), 24 hours a day, 7 days a week. Please have the following information available when initiating your request for prior authorization:

Name of your Medication
Prescriber's Name
Prescriber's Phone Number
Prescriber's Fax Number, if available
Rx member identification number (found on your ID card)

Prior authorization review for standard pre-service claims will be provided within 15 days; for standard, post-service claims, review will be provided within 30 days. If the necessary information to make a determination is not provided by the Prescriber within the decision timeframe, a letter will be sent to the patient and Prescriber describing the information needed and stating that it must be received within 45 days, or the claims will be denied. Prior authorization reviews for urgent claims will be provided within 72 hours, assuming all necessary information is provided. If necessary information is not provided, within 24 hours of receipt, a 48-hour extension will be granted. If the prior authorization request is denied, the Express Scripts's Clinical Pharmacy Department mails a denial letter explaining the denial reason to the person who initiated the request, typically, the Prescriber.

*Plan M*

For Participants in Plan M, prior authorization review for standard claims will be provided within 72 hours, either from receipt of the request for a prior authorization or from the receipt of additional necessary information from the Prescriber. For appeals of denials of prior authorizations, the review will be provided within 7 days from receipt of request for redetermination. Prior authorizations for urgent claims will be provided within 24 hours or either receipt of the request or receipt of the additional necessary information; appeals of urgent claims will be reviewed within 72 hours of the receipt of appeal.

**Medically Necessary**

Prescription services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, condition, disease or its symptoms, that are all of the following as determined by the Plan and administered by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- in accordance with *Generally Accepted Standards of Medical Practice*;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider;
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

*Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

**Over-the-Counter Drugs**

Effective September 1, 2019, the over-the-counter drugs listed in the table below are available with a $0 copayment with a prescription indicating the "OTC" version of the drug. This list may be updated from time to time; please contact the Fund Office for the current list:

| ***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 | | |
| Chewable, pediatric syrups, and the "D" (decongestant) versions of the above are also available at $0 copay. | | |

**Exclusions**

The Board of Trustees may, from time to time, provide for additional exclusions as they deem appropriate. Eligible Charges do not include the following:

a) Any payment for administration of prescription legend drugs;
b) Therapeutic devices or appliances to include support garments;
c) Any medication which can be legally purchased without a prescription is not covered by this Plan, with the exception of those required for compliance with the Patient Protection and Affordable Care Act and as set forth elsewhere in this document.;
d) Other nonmedical substances regardless of their intended use;
e) Drugs or medication which may properly be received without charge under local, state or federal programs;
f) Smoking cessation prescriptions or over-the-counter products in excess of 180 days per year;
g) Brand drugs of which there is an acceptable generic equivalent/substitution. Plan only pays for cost of generic equivalent;

h) Medication in excess of 6 doses per 30-days for medically necessary treatment of male impotence;
i) Effective October 1, 2019, the drugs listed in the below table are excluded for new prescriptions for all plans except Plan M:

| | | |
|---|---|---|
| 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 | Addyi |

j) Drugs for cosmetic purposes, such as hair growth stimulants and wrinkle creams; and
k) Anti-obesity or weight-loss drugs.

## X. DENTAL CARE BENEFITS

| Eligible Employee Classification | Eligible for Benefits |
|---|---|
| Active Employees Eligible Dependents | Yes |
| Class Twenty-Six Employees/Eligible Dependents | Yes |
| Indentured Apprentice/Eligible Dependents | Yes |
| Early Retiree/Eligible Dependents | Dental $250 Benefits |
| Normal Retiree/Eligible Dependents | Dental $250 Benefits |
| Totally and Permanently Disabled Employees/Eligible Dependents | Dental $250 Benefits |
| Surviving Spouse/Surviving Eligible Dependent | Dental $250 Benefits |
| Residential Trainees (Divisions A and B) | No |
| Residential Trainees (Divisions C and D) | Child Only |
| Teledata Employees (Divisions 1 and 2) | Child Only |
| Teledata Employees (Divisions 3 – 6) | Yes |

**Plan A Dental Benefits Administered by Delta Dental**

- Deductible
  a) Unless otherwise provided, each Participant must pay a deductible of $25 per calendar year of Eligible Charges prior to being entitled to Dental Benefits.
- Timeliness of Claim
  a) Dental Benefits are conditioned upon submission of In-Network Dental Claims no later than 12 months following the date the Eligible Charge is incurred. Out-of-Network Dental and secondary coverage Dental claims must be submitted no later than 24 months following the date the Eligible Charge is incurred.
- Maximum Benefit
  a) Maximum benefit per Participant per calendar year is $1,250 excluding orthodontics.
- Eligible Charges/Covered Expenses
  a) Eligible Charges for Medical Benefits include the following:
    a) Preventive (Examination and Cleaning): 2 examinations and cleanings per calendar year. For preventive services, deductible described above does not apply.
    b) Preventative Procedures.
      i. Examination (initial or periodic).
      ii. Cleaning – Adult.
      iii. Cleaning – child (under age 12).
      iv. Fluoride application.
      v. Space maintainers – unilateral.
      vi. Space maintainers – bilateral (available only for individuals under age 19).
      vii. Periodontic Scaling (up to 4 times per year).
      viii. Periodontic cleaning (up to 2 times per year).
      ix. Gingival curettage (up to 4 times per year).
      x. Sealants.
      xi. Emergency Examination.
      xii. All the Preventative Procedures are payable at 100% of the provider fee schedule or the reimbursement schedule as established by the Plan.

c) Diagnostic (X-rays). Diagnostic procedures are payable as Eligible Charges; 85% of the reimbursement amount following satisfaction of the deductible. Diagnostic Services are payable at 85% of the provider fee schedule or the reimbursement schedule as established by the Plan.
    i. Bitewing X-rays (one per calendar year).
    ii. Full mouth series X-rays or Panoramic X-Ray (once every 5 years).
    iii. Periapical X-rays.
    iv. Diagnostic models.

d) Restorative (Filings and Crowns)
Eligible Charges up to 85% of the reimbursement amount for the procedure following satisfaction of the deductible.

The Restorative Services are payable at 85% of the preferred provider fee schedule or the reimbursement schedule as established by the Plan.
    i. Amalgam restorations.
        a. One Surface.
        b. Two Surfaces.
        c. Three Surfaces or More.
    ii. Acrylic or plastic restoration (white fillings).
        a. One Surface.
        b. Two Surfaces.
        c. Three Surfaces or More.
    iii. Fin retention.
    iv. Gold inlay restorations.
        a. One Surface.
        b. Two Surfaces.
        c. Three Surfaces or More.
    v. Onlay.
    vi. Inlay restoration.
    vii. Crowns.
    viii. Cast Post and Core (Per Crown).
    ix. Steel Post with Amalgam or Composite Build-up (Per Crown).
    x. Recement Inlay or Crown.

e) Endodontics (Root Canals)
Eligible Charges up to 85% of the reimbursement amount for the procedure following satisfaction of the deductible.

Endodontic Services are payable at 85% of the preferred provider fee schedule or the reimbursement schedule as established by the Plan.
    i. Pulp cap.
    ii. Vital pulpotomy.
    iii. Root canal therapy, including treatment plan and follow-up care (excludes restoration).
        a. One Canals.
        b. Two Canal.
        c. Three Canals.

f) Prosthodontics – Removable (Dentures)
    i. Complete Dentures (Upper or Lower) and 6 months post care.
    ii. Partial Dentures and 6 months post care.
    iii. Adjustments to Dentures more than 6 months after installation.

iv. Denture relining (once every 36 months).
*v.* Prosthodontics (Removable) are payable as Eligible Charges in an amount equal to 50% of the Reimbursement amount for the procedure following satisfaction of the Deductible.
vi. Includes initial installation of fixed bridgework, including crowns as abutments, Initial installation of partial or full removable dentures.
vii. Includes replacement of an existing removable denture or fixed bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or fixed bridgework, but only if satisfactory evidence is presented that:
    a. replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or
    b. the existing denture or bridgework cannot be made serviceable and, if the charges for its installation were Eligible Charges under this Plan or under any other group plan carried or sponsored by the Eligible Employee, at least five years have elapsed prior to its replacement; or
    c. the existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial installation.
viii. Prosthodontic Services are payable at 50% of the preferred provider fee schedule or reimbursement schedule as established by the Plan.

g) Prosthondontics –Fixed (Dentures)
    i. Bridge Pontics (All Types).
    ii. Repairs –
        a) Replace broken pin facing with
        b) slotted or other facing.
        c) Replace broken facing with acrylic.
    iii. Abutment Crowns (All Types).
    iv. Re-cement Bridge.
    v. Implants.
    vi. Abutmen.
    vii. Implant Crowns.
    viii. Payable as an Eligible Charge equal to 50% of the reimbursement amount following satisfaction of the deductible. Includes initial installation of fixed bridgework, including crowns and abutments, initial installation of partial or full removable dentures, replacement of an existing partial or full removable denture or fixed bridgework by a new denture or fixed bridgework by a new denture or bridgework. Also, include the addition of teeth to an existing partial removable denture or to fixed bridgework, but only if satisfactory evidence is presented that:
        a) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;
        b) The existing denture or bridgework cannot be made serviceable and, if the charges for its installation were

covered expenses under this Plan, at least 5 years have elapsed since the replacement; or

c) The existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

ix. Also, includes installation of bridgework as a replacement for dentures if the bridgework is the only means to attain a professionally adequate result.

x. Includes repair of an existing prosthodontic appliance only if the existing prosthodontic appliance is unserviceable but can be made serviceable. Eligible Charge for such repair is 50% of the reimbursement.

xi. Bridge Pontics, Repairs, Abutment Crowns, and Re-cement bridges are payable at 50% of the preferred provider fee schedule or reimbursement schedule established by the Plan. All other listed Prosthondonitic services are payable at 85% of the preferred provider fee schedule or reimbursement schedule as established by the Plan.

h) Orthodontics (Braces)

i. Orthodontics are payable as Eligible Charges in an amount equal to 50% of the reimbursement amount.

ii. Only payable for a Child who is an Eligible Dependent and who is under the age of 19. Orthodontic billings incurred on or after 19 are not Eligible Charges.

iii. Life maximum payable per Participant for orthodontics, including related extractions, x-rays and surgery is $2,500 effective 2/1/2015.

iv. If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with the last service provided. If treatment is resumed, Benefits for the treatment to the extent remaining shall be resumed.

v. Benefit payments for orthodontic services shall only be made for months during which the Participant is eligible for Dental Benefits. Benefits are paid monthly.

i) Gold, Baked Porcelain Restoration and Crowns and Jackets.

- If a tooth can be restored with a material such as amalgam, but the Claimant and dentist decide on the use of gold, baked porcelain or other more costly material, then the Eligible Charge for such procedure shall equal the applicable percentage of the Reimbursement Amount as if the dentist utilized the less costly material, such as amalgam.

j) Partial Dentures

- If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, but the Claimant and the dentist choose to use a more elaborate, costly or precision appliance, the Eligible Charge for such procedure shall be limited to the applicable percentage of the Reimbursement Amount as if the dentist utilized a cast chrome or acrylic partial denture.

k) Complete Dentures

- If, in the provision of complete denture services, the patient and dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, the Eligible Charges for the procedures shall equal the applicable percentage of the Usual and Customary Charge of the standard denture services only.

- Exclusions. The Board of Trustees may, from time to time, provide for additional exclusions as they deem appropriate.
  The following are excluded:
  a) Charges for services for which Benefits are otherwise provided under this Plan.
  b) Charges for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist.
  c) Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth other the 10 upper and lower anterior teeth.
  d) Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
  e) Charges for prosthetic devices (including bridges), crowns, inlays and onlays, and the fitting thereof which were ordered while the Claimant was not eligible for Dental Benefits or which were ordered while the Claimant was eligible for Dental Benefits but are finally installed or delivered to such individual more than 60 days after terminations of eligibility.
  f) Charges for the replacement of a lost, missing, or stolen prosthetic device.
  g) Charges for a plaque control program.
  h) Charges for failure to keep a scheduled appointment with the dentist.
  i) Charges for replacement or repair of an orthodontic appliance.
  j) Charges for services or supplies for which no charge is made that the Employee is legally obligated to pay or for which no charge would be made in the absence of dental benefits.
  k) Charges for services or supplies which are not necessary according to accepted standards of dental practice.
  l) Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.
  m) Charges for services or supplies received as a result of dental, disease, defect, or injury due to an act of war, declared or undeclared.
  n) Charges for services or supplies from any governmental agency which are obtained by the individual without cost by compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body.
  o) Charges for any duplicate prosthetic device or any other duplicate appliance.
  p) Charges for any services to the extent for which benefits are payable under any health care program supported in whole or in party by funds of the federal government or any state or political subdivision thereof.
  q) Charges for the completion of any insurance forms.
  r) Charges for oral hygiene and dietary instruction.

s) Charges for retainers, thumb guards, or other appliances used to combat oral habits. Charges for bite plates.
t) Charges for nitrous oxide.
u) Charges for occlusal adjustments, or other appliances necessary to increase vertical dimension or restore the occulation.
v) Charges for services or supplies received from a member of the Participant's immediate family. For the purposes of this section, "immediate family" includes the Participant and his or her spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, sisters, children and stepchildren, whether by blood, marriage, or adoption.
w) Dental consultations are not a covered benefit.

**Plan B Dependent Child Dental Care Administered by Delta Dental**

- Deductible – There is no deductible for Covered Dependent Children.
- Timeliness of Claim – Dental Benefits are conditioned upon submission of In-Network Dental Claims no later than 12 months following the date the Eligible Charge is incurred. Out-of-Network Dental and secondary coverage Dental claims must be submitted to the Fund Office no later than 24 months following the date the Eligible Charge is incurred.

- Maximum Benefit – There is no maximum benefit per Covered Dependent Child per calendar year.

- Eligible Charges/Covered Expenses
    a) Preventive Services (Examination and Cleaning): 2 examinations and cleanings per calendar year. Preventive services include:
        i. Examination (initial or periodic)
        ii. Cleaning – child (under age 19)
        iii. Fluoride application
        iv. Space maintainers – unilateral
        v. Space maintainers – bilateral (available only for individuals under age 19).
        vi. Periodontic Scaling (up to 4 times per year)
        vii. Periodontic cleaning (up to 2 times per year)
        viii. Gingival curettage (up to 4 times per year)
        ix. Sealants
        x. Emergency Examination
    b) All the Preventative Procedures are payable at 100% of the provider fee schedule or the reimbursement schedule as established by the Plan.
- Exclusions – The Board of Trustees may, from time to time, provide for additional exclusions as they deem appropriate. The following are excluded:
    a) Charges for non-preventive dental services.
    b) Charges for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist.
    c) Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth other the 10 upper and lower anterior teeth.
    d) Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.

e) Charges for prosthetic devices (including bridges), crowns, inlays and onlays, and the fitting thereof which were ordered while the Claimant was not eligible for Dental Benefits or which were ordered while the Claimant was eligible for Dental Benefits but are finally installed or delivered to such individual more than 60 days after terminations of eligibility.
f) Charges for the replacement of a lost, missing, or stolen prosthetic device.
g) Charges for a plaque control program.
h) Charges for failure to keep a scheduled appointment with the dentist.
i) Charges for replacement or repair of an orthodontic appliance.
j) Charges for services or supplies for which no charge is made that the Employee is legally obligated to pay or for which no charge would be made in the absence of dental benefits
k) Charges for services or supplies which are not necessary according to accepted standards of dental practice
l) Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.
m) Charges for services or supplies received as a result of dental, disease, defect, or injury due to an act of war, declared or undeclared.
n) Charges for services or supplies from any governmental agency which are obtained by the individual without cost by compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body
o) Charges for any duplicate prosthetic device or any other duplicate appliance
p) Charges for any services to the extent for which benefits are payable under any health care program supported in whole or in party by funds of the federal government or any state or political subdivision thereof
q) Charges for the completion of any insurance forms
r) Charges for oral hygiene and dietary instruction
s) Charges for retainers, thumb guards, or other appliances used to combat oral habits. Charges for bite plates
t) Charges for nitrous oxide
u) Charges for occlusal adjustments, or other appliances necessary to increase vertical dimension or restore the occulation
v) Charges for services or supplies received from a member of the Participant's immediate family. For the purposes of this section, "immediate family" includes the Participant and his or her spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, sisters, children and stepchildren, whether by blood, marriage, or adoption.
w) Dental consultations are not a covered benefit.

- All Participants can use Delta Dental dentists to receive discounted treatment. This is not an insurance plan but is a discount program only. The Participant is responsible for non-covered charges.

**Dental $250 Benefits Administered by Delta Dental**

- Dental $250 Benefits are available to the following categories of participants:
    a) Early Retirees
    b) Normal Retirees
        i. NOTE: Members over the age of 65 who maintain Active Eligibility by working more than 300 hours over a three-month test period are eligible for full dental benefits.
    c) Surviving Spouses and Surviving Eligible Dependents

d) Totally and Permanently Disabled Participants

- Deductible – Unless otherwise provided, each Participant must pay a deductible of $25 per calendar year of Eligible Charges prior to being entitled to Dental Benefits.

- Timeliness of Claim – Dental Benefits are conditioned upon submission of In-Network Dental Claims no later than 12 months following the date the Eligible Charge is incurred. Out-of-Network Dental and secondary coverage Dental claims must be submitted to the Fund Office no later than 24 months following the date the Eligible Charge is incurred.

- Maximum Benefit – Maximum benefit per Participant per calendar year is $250.

- Eligible Charges/Covered Expenses – Eligible Charges for Medical Benefits include the following:
  a) Preventive (Examination and Cleaning): 2 examinations and cleanings per calendar year. For preventive services, deductible described above does not apply. Preventative procedures include:
     i) Examination (initial or periodic)
     ii) Cleaning – Adult
     iii) Cleaning – child (under age 12)
     iv) Fluoride application
     v) Space maintainers – unilateral
     vi) Space maintainers – bilateral (available only for individuals under age 19)
     vii) Periodontic Scaling (up to 4 times per year)
     viii) Periodontic cleaning (up to 2 times per year)
     ix) Gingival curettage (up to 4 times per year)
     x) Sealants
     xi) Emergency Examination
     xii) All the Preventative Procedures are payable at 100% of the provider fee schedule or the reimbursement schedule as established by the Plan.
  b) Diagnostic (X-rays): Diagnostic procedures are payable at 85% of the provider fee schedule or the reimbursement schedule as established by the Plan.
     i) Bitewing X-rays (1 per calendar year)
     ii) Full mouth series X-rays or Panoramic X-rays (once every 5 years)
     iii) Periapical X-rays
     iv) Diagnostic models
  c) Participants migrating from Plan A to a Plan offering Dental $250 Benefits due to a mid-year change from Active status to another applicable status are eligible for dental benefits up to the frequency limitations described in this section, i.e. 2 cleanings and exams per year. Benefits received in the calendar year in which the change in status occurred will reduce frequency limits described in this section; however, benefits in excess of the $250 limit received in the calendar year in which the change in status occurred will not reduce the total number of cleanings and exams available to a participant.

## VI. VISION CARE BENEFITS

| Eligible Employee Classification | Eligible for Vision Benefits |
|---|---|
| Active Employees Eligible Dependents | Yes |
| Class Nine-Twenty-Six Eligible Dependents | Yes |
| Indentured Apprentice Eligible Dependents | Yes |
| Early Retiree Eligible Dependents | Yes |
| Normal Retiree Eligible Dependents | Yes |
| Totally and Permanently Disabled Employees Eligible Dependents | No |
| Surviving Spouse/Surviving Eligible Dependent | Yes |
| Residential Trainees (Divisions A and B) | No |
| Residential Trainees (Divisions C and D) | Yes |
| Teledata Employees (Divisions 1 and 2) | Yes |
| Teledata Employees (Divisions 3 – 6) | Yes |

**Vision Benefits Using the VSP PPO**

- Provider: Vision Service Plan (VSP). To find a VSP network doctor go to www.vsp.com or call 800-877-7195.
- Timeliness of Claim: Benefits are conditioned upon being submitted to the Fund Office no later than 24 months following the date that the Eligible Charge is incurred.
- Exclusions and Limitations of Benefits: The Board of Trustees may provide for additional exclusions in the future as they deem appropriate. Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations.

**Patient Options**

- This Plan is designed to cover visual needs rather than cosmetic materials. When the covered participant selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the covered participant will pay the additional costs for the options.
  - Optional cosmetic processes.
  - Anti-reflective coating.
  - Color coating.
  - Mirror coating.
  - Scratch coating.
  - Blended lenses.
  - Cosmetic lenses.
  - Laminated lenses.
  - Oversize lenses.
  - Polycarbonate lenses (except covered children).
  - Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
  - UV (ultraviolet) protected lenses.
  - Certain limitations on low vision care.
  - A frame that costs more than the Plan allowance.
  - Contact lenses (except as noted elsewhere herein).
- Commercial or safety eye glasses are available for Active Employees only..

**Not Covered**

- There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses; or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an Experimental Nature;
- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated in this document as covered Plan Benefits.

- Examinations required as a condition of employment.
- Examinations, services, or materials provided as a result of any Worker's Compensation Law or similar legislation or obtained through or required by any governmental agency or program, whether federal, state, local, or subdivision thereof.
- Treatment for conditions other than refractive after the initial visit. This includes field examinations, their interpretation, and other special diagnostic procedures.

**Medically Necessary:** The Eligible Charges set forth in this Schedule are not required to be Medically Necessary or prescribed by a physician.

## XII. LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

| Eligible Employee Classification | Eligible for Benefits |
|---|---|
| Active Employees | Yes |
| Class Twenty-Six | Yes |
| Indentured Apprentice | Yes |
| Early Retiree | Yes |
| Normal Retiree | Yes |
| Totally and Permanently Disabled Employees | Yes |
| Surviving Spouse/Surviving Eligible Dependent | No |
| Residential Trainees (Divisions A and B) | No |
| Residential Trainees (Divisions C and D) | No |
| Teledata Employees (Divisions 1 and 2) | No |
| Teledata Employees (Divisions 3 – 6) | Yes |

**Life Insurance and ADD**

- Death Benefit : In the event of the death of an Eligible Employee, regardless if the death occurred during the performance of the Employee's employment, the following death benefit shall be paid to the Employee's designated beneficiary:

| Employee Classifications | Amount of Benefit |
|---|---|
| Active Employee, Class 26, or Indentured Apprentice | $10,000 |
| Early Retiree | $2,000 |
| Normal Retiree | $1,000 |

- Accidental Death & Dismemberment (AD&D): In the event an Eligible Employee suffers a loss of life, limb, or sight sustained solely through external, violent, and accidental means, regardless if such accident occurs during the performance of the Eligible Employee's employment, the following AD&D benefit will be paid to the beneficiary, notwithstanding any other Death Benefit paid hereunder.

| Nature of the Injury | Amount of Benefit |
|---|---|
| Loss of life | $10,000 |
| Loss of two limbs | $10,000 |
| Loss of sight of both eyes | $10,000 |
| Loss of one limb and sight in one eye | $10,000 |
| Loss of one limb | $5,000 |
| Loss of Sight in one eye | $5,000 |

- Definition of loss of limb: Loss of Limb means dismemberment by severage at or above the wrist or ankle joint.
- Definition of loss of sight: Loss of Sight means the entire and irrevocable loss of sight.
- Immediacy of loss: Any loss must occur within 90 days of the accident to be covered for AD&D benefits.
- Limitation on multiple losses: If more than one loss covered for AD&D benefits under this Schedule is suffered as a result of any one accident, then no more than $10,000 is payable for the total losses suffered in one accident.

- Exclusions: AD&D benefits shall not be payable for any loss which is:
    i. Caused by or results from suicide or intentionally self-inflicted injury;
    ii. Sustained as the direct or indirect result of insurrection, war, or any act of war; or
    iii. Sustained as the direct or indirect result of any travel or flight in any species of aircraft, except as a far-paying passenger on a licensed aircraft piloted by a licensed passenger pilot on a scheduled air service regularly offered between commercial airports.

## XIII. SHORT TERM DISABILITY

| Eligible Employee Classification | Eligible for Benefits |
|---|---|
| Active Employees | Yes |
| Class Twenty-Six | Yes |
| Indentured Apprentice | Yes |
| Early Retiree | No |
| Normal Retiree | No |
| Totally and Permanently Disabled Employee | Yes |
| Surviving Spouse/Surviving Eligible Dependent | No |
| Residential Trainees (Divisions A and B) | No |
| Residential Trainees (Divisions C and D) | No |
| Teledata Employees (Divisions 1 and 2) | No |
| Teledata Employees (Divisions 3 – 6) | No |

**Short Term Disability**

- Conditions for Disability Benefits:
  - An Eligible Employee shall be eligible to receive Disability Benefits in the event that:
    a) the Eligible Employee becomes disabled and is unable to work because of an injury, accident or sickness.
    b) the injury, accident, or sickness does not arise out of or in the course of their employment entitling the Eligible Employee to benefits under any Workers' Compensation or Occupational disease law.
- Amount of Disability Benefits:
  - The Disability Benefits shall equal
    - 30% of weekly journeyman wages based upon the Journeyman (Classification 1) Wage Rate then in effect under the Inside Collective Bargaining Agreement for a 40-hour week for Active Employees and Indentured Apprentices;
    - 30% of the employee's own Class 26 wage, based on payment for the number of hours normally worked per week, but not to exceed 30% of the weekly journeyman wages for a 40-hour week as described above.
  - A Participant that is on a claim for Disability Benefits can continue participating in the Plan on a $0 pay basis. If a Participant is no longer eligible for benefits under a short-term disability claim but is still off work due to their disability, he or she can continue eligibility on a self-pay waiver basis. The hours earned in the test period prior to their disability will be reactivated when they come off their short-term disability claim and considered in determining their self-pay amount. Once a participant is deemed able to work, normal eligibility and self-pay rules apply.
- Duration of Disability Benefits:
  - Disability Benefits shall be payable for a maximum period of 26 weeks for any one continuous period of disability whether from one or more causes or for successive periods of disability due to the same or related cause or causes.
  - Successive periods of disability separated by less than 2 weeks of continuous active employment shall be considered to be one continuous period of disability unless they arise from different and unrelated causes.

- Application for Disability Benefits:
  - An Participant shall submit an application to the Fund Office for Disability Benefits utilizing the forms designated by the Plan from time to time.
  - An Participant applying for Disability Benefits shall provide to the Administrative Manager verification of the condition of disability as well as verification that the Participant is not eligible for, and is not receiving workers' compensation or unemployment compensation during the period of time for which the claim is made to the Plan.
  - An Participant shall submit an application to the Fund Office for Disability Benefits utilizing the forms designated by the Plan from time to time.
  - All participants receiving Disability Benefits from the Plan shall submit upon request of the Plan Administrator, a statement by the attending Physician regarding the disability.
  - In addition, if requested by the Plan Administrator, the disabled participant shall submit to a physical examination by a medical doctor retained by the Board of Trustees at the expense of the Plan.
- Commencement of Disability Benefits:
  - Disability Benefits are payable to the Covered Employee as of the first day of disability if due to an accident. If the disability is not due to a recent injury/accident, you have a 1 week waiting period. The 1 week waiting period maybe satisfied if you are off work sick for 1 day and you have a physician excuse for the period of absence.
  - No disability will be considered as beginning more than 3 days prior to the first visit to a Physician. Evidence of disability may be required by the Board of Trustees and payment of Benefits may be conditional upon examination by a Trustee-appointed doctor.
- Self – Payment Continuation
  - Rights: In the event a Covered Employee is temporarily disabled at the time of the expiration of self-payment rights under the Plan for continuation of eligibility, the Participant may make additional self-payments at the same rate previously required, provided the Covered Employee submits medical evidence of continued temporary disability to the Fund in order to continue the right to make self-payments beyond the maximum allowed by the Plan.
- Social Security Offset of Disability Benefits:
  - Notwithstanding any provision of this Schedule, the amount of Disability Benefits otherwise payable for any week(s) hereunder shall be reduced or eliminated, as the case may be, by the amount of any Social Security disability income benefits paid or payable for the same week(s) and for the same cause or causes of disability.

The disabled Employee shall provide any information reasonably requested by the Plan Administrator to determine the proper amount of the reduction as a condition of the payment of any Disability Benefits under the Plan.

## XIV. CLAIMS AND APPEALS PROCEDURES

### Filing a Claim

A Participant must file a claim in order to receive benefits. If a Participant fails to follow the claims procedure outlined below, he or she may lose the right to review and/or appeal a determination made by the Plan.

Claim submissions are adjudicated based on their medical necessity as determined by the Plan's utilization review and case management vendors. A claim will not be covered if services are:

- Not medically necessary,
- Experimental,
- Not the most appropriate option available, or
- If you do not agree with the assessment of your claim you may exercise your Appeal Rights (please see below).

Once you file a claim, a determination will be made shortly thereafter of whether the claim is payable. How quickly that determination is made depends on whether the claim is for health care benefits or other benefits provided under the Plan. For health care benefits, the timing of the determination depends on whether the claim is an "urgent care claim," a "concurrent care claim," a "pre-service claim," or a "post-service claim." For all other benefits, a determination will generally be made within 90 days after a claim has been filed.

An "urgent care claim" is any claim for medical treatment which, if delayed, could seriously jeopardize the life or health of the Participant, or his or her ability to regain maximum function, or, in the opinion of a physician who has knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A "concurrent care claim" or "ongoing treatment claim" involves an approved ongoing course of treatment to be provided over a period of time or number of treatments which the Plan wants to end or reduce before the previously approved treatments have ended, or which the Participant has asked to have extended.

A "pre-service claim" means any claim for benefits which, by it terms, conditions the receipt of the benefit in whole or in part on approval of the benefit in advance of obtaining the medical care.

A "post-service claim" means any claim for benefits which, by its terms, conditions the receipt of benefits in whole or in part on the approval of the benefit after obtaining the medical care.

An urgent care claim will be responded to within 24 hours upon receipt. If a determination is made that vital information is lacking in order to process the claim, a Participant is required to receive a request for additional information within 24 hours. In such an event, the Participant will have at least 48 hours to submit the information. Once the information is received, a determination will be made within 48 hours upon receipt.

If an ongoing course of treatment has been approved and a Participant is subsequently notified of a reduction or termination of a benefit for such course of treatment before the end of the

previously approved period, the Participant will be notified sufficiently in advance of the reduction or termination in order to allow the Participant to appeal and obtain a decision before the benefit is reduced or terminated. If a Participant requests an extension of the course of treatment beyond the originally approved period of time or number of treatments and the claim involves urgent care, a decision will be made within 24 hours after the receipt of the claim so long as the claim has been made by the Participant at least twenty-four 24 hours before the expiration of the originally approved period of time or number of treatments.

A pre-service claim will be responded to within 15 days. This period may be extended due to circumstances beyond the Plan or the Plan Administrator's control. If the period is extended, a Participant must be notified of the extension before the end of the 15 day period. If the extension is due to insufficient information, the Participant will have 45 days after receiving notice from the Plan within which to provide the required information.

A post-service claim will be responded to within 30 days after receipt of the claim. This period may be extended one time for up to 15 days due to circumstances beyond the control of the Plan or the Plan Administrator. If the period is extended, the Participant must be notified before the expiration of the original 30 day period. If the extension is due to a failure to submit necessary information, the notice of extension will describe the required information and the Participant will have 45 days to provide the necessary information.

Disability claims will be responded to within 45 days after receipt of the claim. This period may be extended by the Plan two separate times for up to 30 days each due to circumstances beyond the Plan or Plan Administrator's control. If the period is extended, the Plan must provide notice to the Participant before the end of the original 45 day period. If additional information is required, the Plan will notify the Participant and he or she will have 45 days from receipt of that notice to furnish the required information.

**Denial of a Claim**

If the Plan denies a claim, either partially or totally, then the Plan Administrator will provide the Participant with a written notice of the denial. The notice will explain why the claim was denied and will reference specific Plan provisions. The notice will also describe any additional information that is necessary along with an explanation as to why the additional information is needed.

**Internal Appeals Process**

If the Plan partially or totally denies a claim, a Participant may appeal in writing to the Plan Administrator within 180 days of the decision to deny the claim. The following chart summarizes how quickly an appeal must be reviewed and when a response must be provided:

| Type of Appeal | | Response Time |
|---|---|---|
| Urgent Care | | 24 hours when feasible;<br>not to exceed 72 hours |
| Pre-Service | | 15 days |
| Post-Service | | 30 days |

Once a decision is made, the Participant will be immediately notified. If the Appeal is denied the notification will explain why the Appeal was denied, will reference specific plan provisions, and will explain the right to bring a civil action.

**Tip:** Whenever dealing with insurance coverage, you should make a copy of everything you send in the mail. Keep track of dates that you call as well as names of the employees you speak with.

**Standard Appeals Process**
If a Participant does not agree with the Plan's decision after exhausting the internal appeal procedure, they may request an External Review. The request for an external appeal must be in writing. This can be done up to 4 months after the final internal decision. The Plan will determine within 5 days whether the request is eligible for external review and notify the participant within one business day after completing their determination.

The Plan will assign an Independent Review Organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or a similar national organization to conduct the external review. The IRO will make a determination within 45 days. The IRO may request additional information from the Participant who must provide the information within ten days. If the IRO reverses the Plan's benefit determination, the Plan will immediately provide coverage or payment for the claim.

**Expedited Appeals Process**
A Participant may request an expedited external review if they:

1. receive an adverse benefit decision,

2. cannot wait for a standard external appeal as the time frames associated with a standard review would seriously jeopardize their life or health or their ability to regain maximum function, or

3. are appealing a claim involving an admission, availability of care, continued stay and have not been discharged from the facility, or emergency services.

The appeal must be in writing. The Plan will immediately determine whether the request is eligible for an expedited external review and will assign it to an IRO. The IRO will make their determination as expeditiously as possibly but within 72 hours.

If assistance is required understanding your rights under the Patient Protection and Affordability Act, a Participant may contact Health and Human Services Office of Consumer Assistance in their state. A listing of the offices can be viewed at healthcare.gov.

**Request for Plan Information**
You have the right to inspect all Plan documents and make copies of those documents. All documents can be reviewed and copied during normal business hours at the Toledo Electrical Welfare Fund Office, 727 Lime City Road, Suite 200, Rossford, Ohio 43460. In accordance with Internal Revenue Service regulations, the Plan may charge a reasonable fee for copies. Any such request or other requests regarding Plan operation should be directed to the Plan Administrator.

**Employment Rights**
Nothing in the Plan or Summary Plan Description in any way creates an express or implied contract of employment. Your employment may be suspended, changed, or otherwise terminated by either you or the Employer at any time.

**No Warranty of Health Care Providers**
Nothing in the Plan or this Summary Plan Description in any way creates an express or implied contract of employment. Your employment may be suspended, changed, or otherwise terminated by either you or the Employer at any time.

**Disability Appeals**
Special rules apply to appeals of the Plan's denial of a disability application. The Plan will make available to the applicant information relevant to the application, including any medical protocols or standards used (or furnish a statement that none exist). If experts were consulted, the Plan will furnish this information, even if not used in the decision making process. You may receive all documents and records relevant to your claim.

The applicant may submit comments, document, records and other information related to the application. The Board of Trustees will consider on review all information furnished by the applicant, regardless of whether the information was submitted or considered initially, and independent of that initial determination. If a medical judgment is involved, the Board of Trustees will consult with an appropriate health professional. You will be furnished with any new or additional evidence on appeal, and given an opportunity to respond before action is taken on your appeal.

**Prescription Drug Benefit Appeals**
Appeals for the Plan's denial of a prescription drug claim are reviewed by the Plan's Pharmacy Benefit Manager, Express Scripts. Written appeals can be submitted to Express Scripts directly at:

Clinical Appeals Department
Express Scripts
PO Box 66588
St. Louis, MO 63166-6588

Fax: 877.852.4070
Phone: 800.753.2851

Appeals for the denial of prescription drug claim for a Participant in Plan M must be sent to:

Medicare Clinical Appeals
PO Box 66588
St. Louis, MO 63166-6588

Fax: 877.852.4070

The internal, external, and expedited appeals process is otherwise the same as the process for medical claims.

## XV. ADMINISTRATION OF THE FUND

**Payments of Benefits Limited to Plan**
All benefits under the Plan shall be payable through employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Plan can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, any Employer or the Trustees. The Trustees, the Employers and the Union shall not be held liable for any benefits except as provided in the Agreement(s) between the Employers and Union.

**Validity of Plan and Plan Provisions**
This Welfare Plan is established in the State of Ohio and all questions pertaining to the validity and construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Ohio, except as preempted by Federal law. Where all or part of a Plan provision is declared invalid, any remaining balance of such provision will remain valid.

**Construction by Trustees**
Under the Plan of Benefits and the Trust Agreement creating the Plan, the Trustees or persons acting for them, such as a Trustee Sub-Committee, have the sole and exclusive authority to make final determinations regarding any application for benefits and the interpretation of the Plan, the Trust Agreement, the Plan documents or any other rules, regulations, procedures or administrative rules adopted by the Trustees. Any questions or interpretations about the Plan or Trust Agreement, or disputes about eligibility for an amount of benefits, shall be resolved by the Board of Trustees in their sole and exclusive discretion. Decisions of the Trustees or, where appropriate, decisions of those acting for the Trustees in such matters, are final, binding and conclusive on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the further intention of the parties to the Trust that such a decision is to be upheld unless it is determined to be arbitrary and capricious.

Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the claimant's right to legal action, be final and binding on all parties.

**Amendment and Termination**
While it is expected that this Plan will continue forever, circumstances may arise that require this Plan, or any component, to be amended or terminated. Therefore, the Plan Administrator reserves the right to amend, modify, or terminate this Plan or any component of this Plan at any time. If action is taken which results in the termination of coverage under the Plan, any claims incurred prior to such action will be paid. To the extent allowed by law, claims incurred on or after such action will not be paid.

**Maximum Cost Sharing**
The Plan operates in compliance with the Patient Protection and Affordable Care Act (PPACA) and limits in-network participant out-of-pocket expenses for essential health benefits. Notwithstanding anything herein, effective January 1, 2014, all essential health benefits that may be included in this Plan that are provided by Network Providers are subject to an Out-of-Pocket Maximum per benefit period that does not exceed $8,150 for single coverage and $16,300 for family coverage (2020 limits). These dollar amounts are subject to change each

year, in accordance with federal guidelines. The Out-of-Pocket Maximum includes any deductibles, coinsurance, and copayments that are applicable under the plan.

**Pre-existing Conditions**
This Plan cannot and does not apply a preexisting condition provision; therefore certificates of creditable coverage will no longer be necessary. This provision is effective January 1, 2014. For Participants or Dependents under 19 years of age, this provision was effective January 1, 2011.

**Reservation of Rights**
Benefits have been made available by the Board of Trustees as a privilege, not a right. No person acquires a vested right to such Benefits, either before or after their retirement. The Trustees may expand, reduce or cancel coverage for Active Employees, Class 26 Employees, Totally and Permanently Disabled Employees, Indentured Apprentices, Normal Retirees, Early Retirees, Eligible Dependents, Surviving Spouses, Surviving Eligible Dependents, and individuals eligible for Base Only Benefits; change eligibility requirements or the amount of contributions; and otherwise exercise their prudent discretion at any time without legal right or recourse by any Active Employees, Class 26 Employees, Totally and Permanently Disabled Employees, Indentured Apprentices, Normal Retirees, Early Retirees, Eligible Dependents, Surviving Spouses, Surviving Eligible Dependents, or individuals eligible for Base Only Benefits, or any other person.

**Nonassignability of Rights**
Except to the extent an Participant assigns his Benefit to a Provider, the right of any Participant to receive Benefits from the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to creditors by any process; and any attempt to cause such right to Benefits to be so subjected will not be recognized except to such extent as may be required by law and to the extent necessary to satisfy a judgment for unpaid contributions to this Plan or any other third party beneficiary of an applicable collective bargaining agreement between the Union and the Association with respect to which the Participant has personal liability.

## XVI. SUBROGATION AND REIMBURSEMENT, RECOVERY OF OVERPAYMENT

### Subrogation

The Plan reserves the right of subrogation. This means that, to the extent we provide or pay benefits or expenses, including Short-Term Disability benefits, we assume your legal rights to recover the value of those benefits or expenses from any person, entity, organization or insurer, including your own insurer, Workers' Compensation, and any under insured or uninsured coverage, that may be legally obligated to pay you for the value of those benefits or expenses. The amount of the Plan's subrogation rights shall equal the total amount paid by the Plan for the benefits or expenses. The Plan's right of subrogation shall have priority over yours, your attorney's or anyone else's rights until the Plan recovers the total amount the Plan paid for Benefits. The Plan's right of subrogation for the total amount the Plan paid for Benefits is absolute and applies whether or not you receive, a full or partial recovery or whether or not you are "made whole" by any reason of any recovery from any other person or entity. This provision is intended to and does reject and supersede the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of subrogation.

In addition, the Plan will be subrogated (to the extent of any benefit payments made) to the rights and remedies of the Participant (or his covered Dependents) against any such third party and may bring an action as the Participant's (or covered Dependent's) subrogee to enforce such rights.

### Reimbursement

Further, the Plan shall be entitled to reimbursement from a Eligible Person to the extent of any amounts paid, or amounts payable on behalf of, the Eligible Person (including his or her covered Dependent) from a third party or insurer by way of settlement, judgment, agreement or otherwise. Accordingly, the Plan shall have a lien, to the extent of the benefits provided or reasonably expected to be provided in the future based on a competent medical opinion, to any money, property, or right of payment that an Eligible Person or his covered Dependent is entitled to as a means of recovery against such a third party. As a result, an Eligible Person agrees to set aside any amounts received from a third party in a separate and independent account until any and all subrogation claims can be resolved.

Any "Make Whole" doctrine or "Common Fund" doctrine will not apply in any subrogation or reimbursement action involving the Plan to the extent permissible under Federal law. Therefore, there shall be no reduction in the amount due to the Plan for any costs of suit or attorneys' fees incurred by the Eligible Person. Further, there shall be no percentage reduction of reimbursement to the Plan because the Eligible Person has received less than complete compensation from any third party or insurer. State anti-subrogation law does not apply to this Plan.

### Your Duties

- You must complete and sign a subrogation agreement, acknowledging and agreeing to the Plan's security interest in the proceeds of any claim you have against any other party; executing a subrogation agreement is a condition precedent to receiving any Benefits from the Plan after an incident that may give rise to a subrogation claim.

- You must provide the Plan or its designee any information requested by the Plan or its designee within 5 days of the request.

- You must notify the Plan or its designee promptly of how, when and where an accident or incident resulting in personal injury to you occurred and all information regarding the parties involved.

- You must cooperate with the Plan or its designee in the investigation, settlement and protection of the Plan's right.

- You must send the Plan or its designee copies of any police report, notices or other papers received in connection with the accident or incident resulting in personal injury to you.

- You must not settle or compromise any claims unless the Plan or its designee is notified and the Plan or its designee agrees to it in writing.

**Discretionary Authority**
The Plan shall have discretionary authority to interpret and construe the terms and conditions of the Subrogation and Reimbursement provisions and make determination or construction which is not arbitrary and capricious. The Plan's determination will be final and conclusive.

**Recovery of Overpayment**
If the Fund Office determines that any Participant has received an erroneous overpayment of a benefit, whether as a result of a refusal by a Participant to reimburse the Plan in accordance with the Plan's Subrogation rights, an administrative error by the Plan, or any other reason, the Fund Office will notify that person in writing, explaining the nature of the erroneous overpayment and requesting return of the overpayment. If the initial request for restitution is not successful, the Fund Office may take other reasonable actions to obtain reimbursement of the erroneous overpayment.

If taking reasonable steps to obtain repayment of the overpayment has been unsuccessful, the Fund Office may treat the overpayment of benefits as an advance payment of benefits due to the Participant and offset the amount of such overpayment against any Plan benefits due or which may become due to the Participant until the full amount of the overpayment has been repaid to the Plan.

The Fund Office may offset benefits due or which may become due to the Participant from the Employee Retention Program or the Supplemental Fringe Benefit Fund (together, the "Fringe Benefit Funds") for overpayments made from the Plan. Further, the Fund Office may also offset benefits due or which may become due to the Participant from this Plan for overpayments made from the Fringe Benefit Funds, to the full extent of such overpayment.

## XVII. LEGAL NOTICES

**Genetic Information Nondiscrimination Act of 2008 ("GINA").**
GINA is effective as of January 1, 2010. This Plan intends to comply with GINA and any applicable regulations issued under it. The Plan and Plan Sponsor are prohibited from collecting, using or disclosing genetic information for determining individual eligibility, benefits, or premiums, or for underwriting purposes. Nor does the Plan discriminate based on health condition.

**Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice**
This Notice of Privacy Practices ("Notice") applies to Protected Health Information associated with the Plan. This Notice describes how the Plan may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice. If we make material changes to our privacy practices, copies of revised notices will be mailed to all participants then covered by the Plan. Copies of our current Notice may be obtained by contacting the Administrative Manager, Toledo Electrical Welfare Fund, 727 Lime City Road, Suite 200, Rossford, Ohio 43460, (419) 666-4450.

The Plan treats your medical information as confidential. However, the Plan must use and disclose medical information to others for treatment, payment, and health care operations. Medical information may be disclosed for (i) payment by, for example, sending your information to insurance companies to help the Plan's purchase of insurance, or to others if there may be duplicate coverage requiring Coordination of Benefits; and (ii) health care operations by, for example, disclosing information to utilization review groups, and contacting you and/or your medical providers about treatment alternatives and health-related Benefits. Your medical information is sometimes disclosed to the Plan's Board of Trustees for Plan administration—for example, to act on claim appeals. The Plan uses information for underwriting purposes but is prohibited from using any genetic information for such purposes.

The Plan is generally required to disclose health information to you, and when required by the Secretary of Health and Human Services to determine Plan compliance. The Plan is also permitted and may be required to disclose information to public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse, and other public health issues; to health oversight agencies, such as governmental auditors, a State Department of Health, and other agencies when required; to avert a serious threat to health or safety; to any individual when ordered by a court or other legal process to do so; to law enforcement officials when necessary for law enforcement purposes and permitted or required by law; to a coroner or medical examiner when necessary to enable them to perform their duties; to organ procurement organizations, to enable them to make suitability determinations; in cases of emergency; for workers' compensation; to appropriate military authorities, if you are a member of the armed forces; to federal officials for lawful intelligence, counter-intelligence and other national security purposes; to researchers if their research has been approved by an institutional review board or other board as may be permitted by HIPAA and they take certain steps to protect your privacy; and incident to a permitted or required use or disclosure, for which the Plan has complied with HIPAA's requirements.

The Plan will make other uses and disclosures of your medical information, including those not otherwise permitted or required by law only with your written authorization. These include uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or any

disclosure constituting a sale of such information. You have the right to revoke any authorization you provide us.

*Your Rights:*
For your private health information, you have certain rights:

- To request restrictions on certain uses and disclosures (for example, if the health care provider has been totally paid by your Out-of-Pocket payments), but the Plan is required to agree to such a restriction only in limited circumstances;

- To request communications by alternative means or at alternative locations stated in writing;

- To generally inspect and receive a copy such information (for a Reasonable fee);

- To request amendment of information if you furnish your reason in writing;

- To receive an accounting of certain uses and disclosures other than those to carry out treatment, payment or health care operations and certain other exceptions, and to receive an accounting of certain uses and disclosures made through electronic health records to carry out treatment, payment, or health care operations; and

- To receive a paper copy of this Privacy Policy upon request.

You may exercise the above rights by writing to the Privacy Officer at the address shown below. The Privacy Officer is the Administrative Manager.

*Our Obligations:*
This Plan must:

- Maintain the privacy of protected health information according to law and our policies and procedures;

- Furnish you with notice of the Plan's Privacy Policy and privacy practices with respect to your medical information, and act in accordance with the Plan's Policy, practices, and this notice;

- Notify you of any breach of unsecured protected health information; and

- Notify you in writing of a change in the Plan's Privacy Policy, privacy practices, or this notice, which change may be effective for protected health information received before the change.

You should contact the Plan's Privacy Officer, at the below address, for further information or to express any concerns. If the matter is not resolved or you believe your privacy rights have been violated, you should file a written complaint with the Privacy Officer, Toledo Electrical Welfare Fund, P.O. Box 60408, Rossford, Ohio 43460. You will not be retaliated against for any complaint. You may also file a complaint with the Secretary of Health and Human Services.

The Plan is required by law to notify affected individuals following a breach of unsecured Protected Health Information.

**Mental Health Parity**
The Mental Health Parity and Addiction Equity Act of 2008 amends the Employee Retirement Income Security Act ("ERISA") to prohibit health plans from imposing any caps or limitations on mental health or substance abuse benefits that aren't applied to medical and surgical benefits. While the Mental Health Parity and Addiction Equity Act does not require plans to provide these benefits, plans that choose to provide mental health and substance abuse benefits must be provided in parity with medical and surgical benefits.

This Plan intends to comply with the Mental Health Parity and Addiction Equity Act and any applicable regulation issued under it. Therefore, this Plan does not impose financial requirements or treatment limitations on mental health and substance abuse benefits that are more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits.

**Newborn's Act Disclosure**
Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or his or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Uniformed Services Employment and Reemployment Rights Act ("USERRA")**
For information about your rights under USERRA, see "Employees Service in the Armed Forces" on page 21 of the Plan.

**Women's Health & Cancer Rights Act**
If you have had or are going to have a mastectomy, this Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides Benefits for mastectomy-related services, including all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to achieve symmetrical appearance; prostheses; and treatment of physical complications resulting from a mastectomy, including lymphedema. Call the Administrative Manager at (419) 666-4450 for more information.

## XVIII. STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT SECURITY ACT OF 1974 (ERISA)

As a Participant in the Toledo Electrical Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About Your Plan and Benefits**
You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration "(EBSA").

You may also obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

You will receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**
In certain instances, you will be able to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event, as described in Section IV. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**
In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide you should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Fund Office at (419) 666-4450. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of EBSA, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA, or visiting dol.gov/ebsa.

## XIX. DEFINITIONS

The following terms shall have the meanings set forth in this Section XIX when used in the Plan, unless a different meaning is plainly required by the context. In addition, terms defined in the Trust Agreement shall be incorporated herein by reference and shall have the same meaning unless a different meaning is plainly required by the context,

**Active Employee.** "Active Employee" means an Employee who is employed in Covered Employment by an Employer and satisfies the eligibility requirements set forth in this booklet.

**Adverse Benefit Determination.** "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Claim for Benefits, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan; a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from a determination that a Benefit is not a covered benefit or the application of any Utilization Review; a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate; or a rescission of coverage, regardless of the effect on any Benefit at that time.

**Age.** "Age" means the age that an individual attained at the individual's latest birthday.

**Authorized Representative.** "Authorized Representative" means the individual or individuals who have been designated by a Claimant to receive information from the Plan Administrator with respect to any Claim for Benefits that entails notification of the Administrator's action on the Claim. An Authorized Representative shall be named by the Claimant by filing a written designation to that effect with the Fund Office, except that, in a situation involving an Urgent Care Claim, (1) the designation may be made orally, and (2) a Health Care Professional with knowledge of the Claimant's medical condition shall be recognized as the Claimant's Authorized Representative.

**Base Only Benefits.** "Base Only Benefits" means the Benefits for Participants available in accordance with the Section "Base Only Benefits."

**Benefit.** "Benefit" means the amounts reimbursed or paid to or on behalf of an Participant for Eligible Charges.

**Benefit Determination.** "Benefit Determination" means an action of the Plan Administrator to grant or deny a Claim for Benefits.

**Board of Trustees.** "Board of Trustees" or "Trustees" means the Board of Trustees of the Toledo Electrical Welfare Fund.

**Cable Puller.** "Cable Puller" has the same meaning as set forth in the Voice Data and Video Supplement to the National Teledata Agreement for the IBEW Fourth District, as modified, amended and supplemented from time to time.

**Child.** "Child" means:

- the natural child of an Eligible Employee;

- an adopted child of an Eligible Employee. A child will be considered an adopted child as of the time that the Eligible Employee becomes legally responsible for the total or partial support of such child in anticipation of adopting such child, irrespective of whether such adoption has become final; or
- a child for whom the Eligible Employee or the Eligible Employee's Spouse can produce documentation satisfactory to the Board of Trustees establishing that the Eligible Employee or the Eligible Employee's Spouse is legally obligated to and has assumed the legal obligation to provide health care for such child, such as a stepchild, grandchild or grandchild.

The Board of Trustees reserve the right to require that the Eligible Employee, as frequently as may be necessary, submit evidence necessary to establish such legal responsibility for support, including, but not limited to, an order or other judgment entry of the probate court.

**Claimant.** "Claimant" means any Participant who has filed a Claim for Benefits under the Plan.

**Claim for Benefits.** "Claim for Benefits" or "Claim" means a written application for Benefits under the Plan filed by a Claimant or his or her Authorized Representative.

**Class Twenty-Six Employee.** "Class 26 Employee" means an Employee that is employed by an Employer under terms of employment or in a position not governed by the Collective Bargaining Agreement and satisfies the eligibility requirements set forth in this booklet.

**Code.** "Code" means the Internal Revenue Code of 1986, as the same may be amended.

**Collective Bargaining Agreement.** "Collective Bargaining Agreement" means the Inside Agreement between National Electrical Contractors Association, Ohio/Michigan Chapter and International Brotherhood of Electrical Workers Local Union No. 8 in effect.

**Concurrent Care Claim.** "Concurrent Care Claim" means a Claim for an extension of the duration or number of treatments provided pursuant to a previously-approved Claim for Benefits.

**Covered Employee.** "Covered Employee" means an Active Employee, Class 26 Employee, Journeyman-in-Training, or an Indentured Apprentice.

**Covered Employment.** "Covered Employment" means employment as a journeyman, apprentice, or otherwise which is governed by the Collective Bargaining Agreement. Covered Employment also means employment as common law employee as a Class 26 Employee for an Employer that has executed a Participation Agreement with the Board, but only to the extent that such employment satisfies any terms and conditions set forth in this Plan or in such Participation Agreement.

**Death Benefits.** "Death Benefits" means the Benefits available in accordance Section XII..

**Dental Benefits.** "Dental Benefits" means the Eligible Charges for the items, procedures, and services set forth in this booklet.

**Disability Benefits.** "Disability Benefits" means the Benefits available in accordance with this booklet.

**Early Retiree.** "Early Retiree" means a person who was, but is no longer eligible for Benefits as an Active Employee, Class 26 Employee, or Indentured Apprentice and satisfies the requirements for eligibility as an Early Retiree set forth in this booklet.

**Electrical Work.** "Electrical Work" means any and all types of electrical work covered by collective bargaining agreements to which the IBEW, AFL-CIO, and/or any affiliated Local Union is a party, or under the trade jurisdiction of the IBEW Constitution.

**Electronic Notice.** "Electronic Notice" means Notice given by the Plan to a Claimant or his or her Authorized Representative by electronic mail or through an interactive Intranet site on the world wide web (the "Internet"), provided that:

- The Plan Administrator assures that the electronic-based system for furnishing documents results in actual receipt by Claimants or their Authorized Representatives of transmitted information and documents by the return-receipt feature (in the case of e-mail), or conduct periodic reviews or surveys to confirm receipt of transmitted information;
- The electronic-based system for furnishing documents protects the confidentiality of personal information, relating to the Claimants' accounts and benefits, by the use of measures designed to preclude unauthorized receipt of or access to such information by individuals other than the Claimant or his or her Authorized Representative for whom the information is intended;
- Each Claimant is provided notice, through electronic means or in writing, apprising the Claimants of the document(s) to be furnished electronically, the significance of the document (e.g., the document describes changes in the benefits provided by your plan) and the participant's right to request and receive, free of charge, a paper copy of each such document; and
- Each Claimant or his or her Authorized Representative participant is provided upon request a paper copy of the document delivered to the Claimant or Authorized Representative participant through electronic media.

**Eligible Charges.** "Eligible Charges" means the expenses covered for payment or reimbursement to or on behalf of an Participant as Benefits.

**Eligible Dependent.** "Eligible Dependent" means any of the following:

- The Spouse of the Eligible Employee provided such Spouse:
    - Elects to enroll in the most beneficial coverage available under any group health plan offered through the Spouse's employment, if any, at a cost to the Spouse of up to the limit determined by the Trustees from time to time. In the event that the Spouse is eligible for more than one alternative for health coverage pursuant to the Spouse's employment, then the most beneficial coverage to the Spouse shall be presumed to be the most expensive alternative available unless the Spouse demonstrates to the Trustees satisfaction that a lower cost alternative of health coverage would provide greater health benefits in the Spouse's particular situation.
    - For purposes of this definition, "group health plan" shall have the same definition as under ERISA §733(a), 29 U.S.C. §1191b(a).

  The Trustees reserve the right to require that an Eligible Employee or an Eligible Employee's Spouse, as frequently as may be deemed necessary, submit evidence of

Eligible Employee's Spouse's employment and enrollment in a group health plan offered through the Spouse's employment.

- A Child:
    - Who is under age 26 (such Child is an Eligible Dependent until the last day of the month in which his or her 26th birthday occurs).
    - Who is unmarried, is totally and permanently disabled, and was covered under the Plan immediately before reaching age 26. The Board of Trustees reserves the right to require the Child to submit to periodic medical review to confirm ongoing physical or mental handicap, but no more than once every year after the two years immediately following the date of the initial proof.

**Eligible Employee.** "Eligible Employee" means an Active Employee, Class Twenty-Six Employee, Early Retiree, Normal Retiree, Totally and Permanently Disabled Employee, Journeyman-in-Training, Indentured Apprentice or individual entitled to Base Only Benefits.

**Eligible Person.** "Eligible Person" means an individual entitled to Benefits under the terms of the Plan.

**Employee.** "Employee" means a common law employee of an Employer.

**Employer.** "Employer" means an employer who is a signatory to the Collective Bargaining Agreement or who has executed a Participation Agreement to the satisfaction of the Board of Trustees.

**ERISA.** "ERISA" means Employee Retirement Income Security Act of 1974, as amended.

**Fund Office.** "Fund Office" means the office of the Plan Administrator located at 727 Lime City Road, Rossford, Ohio 43460.

**Health Care Professional.** "Health Care Professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

**Hearing Benefits.** "Hearing Benefits" means the Benefits for Participants in accordance with this booklet.

**Indentured Apprentice.** "Indentured Apprentice" means an Employee who is certified by the Administrative Manager of the Local No. 8, I.B.E.W. Joint Apprenticeship and Training Plan and Trust as an Indentured Apprentice, and who has commenced Covered Employment.

**Journeyman-in-Training.** "Journeyman-in-Training" means an Employee that satisfies the eligibility requirements set forth in this booklet.

**Medically Necessary.** "Medically Necessary" means the service or supply is:

- Consistent with the symptoms or diagnosis and treatment of the Participant's illness or injury;
- Appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States;

- Not solely for the Participant's convenience or that of his or her physician or the facility at which the Participant receives treatment; and
- Performed in the least costly setting where service can be safely and appropriately provided (for example, rendered to the Participant as an inpatient only when the services cannot be safely, provided on an outpatient basis).

**Medical Benefits.** "Medical Benefits" means the Benefits for Participants in accordance with this booklet.

**Normal Retiree.** "Normal Retiree" means an individual who was, but is no longer eligible for Benefits as an Active Employee, Class Twenty-Six Employee, Indentured Apprentice, or an Early Retiree and satisfies the eligibility requirements of a Normal Retiree set forth in this booklet.

**Notice.** "Notice" means the delivery or furnishing of information to an individual relating to the Plan.

**Participant.** "Participant" means an Eligible Person who is actually receiving Benefits from the Plan.

**Part-Time Employee.** "Part-Time Employee" means an Employee who either:

- Normally works less than 20 hours per week; or
- Works less than 880 hours per year.

**Personal Assistance Benefits.** "Personal Assistance Benefits" means the Benefits available in accordance with this booklet.

**Plan.** "Plan" means the Toledo Electrical Welfare Fund Self-Funded Plan.

**Plan Administrator.** "Plan Administrator" means the Board of Trustees.

**Post-Service Claim.** "Post-Service Claim" means any Claim for Benefits under the Plan that is not a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim.

**Pre-Existing Condition.** "Pre-Existing Condition" means an illness, injury or medical condition (other than pregnancy), which exists on the effective date of eligibility and for which the Participant has received medical advice, diagnosis, care, or treatment within the 6 month period ending on the Participant's enrollment date. For purposes of this definition, the Participant's "enrollment date" means the earlier of (i) the date as of which the Participant first becomes eligible for benefits under the provisions of Article. II hereof, or (ii) the first day of the period of 3 consecutive calendar months considered in establishing the Participant's initial eligibility in accordance with Article II hereof, as the case may be.

**Preferred Provider Organization.** "Preferred Provider Organization" means the entity with whom the Plan enters into an agreement or contract from time to time to act as the Plan's preferred provider organization.

**Prescription Drug Benefits.** "Prescription Drug Benefits" means the Benefits available in accordance with this booklet.

**Pre-Service Claim.** "Pre-Service Claim" means any Claim for a Benefit under the Plan with respect to which the terms of the Plan condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining medical care.

**Reimbursement.** "Reimbursement" means:

- The contracted amount as used by the Preferred Provider Organization;
- The amount directly contracted for between the Plan and a health care provider (doctor, hospital, or facility);
- The amount determined through an alternate designee such as a re-pricing organization or other negotiating entity on the Plan's behalf; or
- In the absence of any of the above, the amount shall equal the Usual and Customary amount as determined by the Plan.

**Spouse.** "Spouse" means an individual who is married to the Eligible Employee in a legally recognized civil or religious ceremony. An Eligible Employee's common-law spouse shall be considered a Spouse for purposes of the Plan if the Eligible Employee and his or her alleged Spouse offer proof in a form satisfactory to the Board of Trustees that the couple fulfill all of the conditions of a common-law marriage that the Eligible Employee's state of domicile requires, to the extent such state recognizes common-law marriage.

**Surviving Eligible Dependent.** "Surviving Eligible Dependent" means an Eligible Dependent of a deceased Eligible Employee who was alive at the time of the Eligible Employee's death or born within 9 months thereafter, and who satisfies the eligibility requirements of this booklet.

**Surviving Spouse.** "Surviving Spouse" means a Spouse of a deceased Eligible Employee who satisfies the eligibility requirements of this booklet.

**Telemedicine Services.** "Telemedicine Services" means two-way, real time interactive communication between Participants and Physicians via interactive telecommunications equipment such as video conferencing and smartphones. It allows healthcare providers to evaluate, diagnose and treat patients without the need for an in-person visit.

**Total and Permanent Disability.** "Total and Permanent Disability" or 'Permanent Disability" means that an individual is incapacitated by reason of any medically demonstrable physical evidence or medical condition which:

- Affects his or her ability to the extent that he or she is unable to engage in and regularly perform the duties of his or her occupation as an electrician or, in the case of an individual who is a Class Twenty-Six Employee, such occupation in which he or she is engaged and regularly performing immediately before being incapacitated; or
- Endangers his or her life to engage in and regularly perform the duties of his or her occupation as determined in accordance with a competent medical opinion.

A disability shall be deemed to be permanent if, in competent medical opinion, it may be expected to continue for the remainder of the individual's natural life.

**Total and Permanently Disabled Employee.** "Total and Permanently Disabled Employee" means a Covered Employee that has suffered a Total and Permanent Disability and satisfies the eligibility requirements set forth in this booklet.

**Trust Agreement.** "Trust Agreement" means the Amended and Restated Declaration of Trust by and between the Union and the National Electrical Contractors Association, Ohio/Michigan Chapter.

**Unacceptable Work.** "Unacceptable Work" means employment for an employer engaged in Electrical Work, or as a self-employed individual engaged in Electrical Work, if such employer, or self-employed individual as the case maybe, is not a party to a collective bargaining agreement with the IBEW or AFL-CIO (or a local Union affiliated with the IBEW or AFL-CIO).

**Uniformed Services.** "Uniformed Services" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

**Union.** "Union" means the Local No. 8, International Brotherhood of Electrical Workers.

**Urgent Care Claim.** "Urgent Care Claim" means any Claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations specified in this booklet:

- Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or
- In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

**Usual and Customary.** "Usual and Customary" refers to the allowable expense that the Plan will accept for a given treatment or procedure. The term "usual" means charges for services and supplies which are broadly accepted professionally and essential to the care of the Participant. The term "customary" means the charge for a service or supply that is the lesser of:

- The charge most frequently made for it by the provider who furnishes it; or
- The average charge by a majority of health providers in that geographic area for the same or similar service or supply.

For purposes of determining the usual and customary charge of a majority or health care providers in the geographical area for a specific surgical procedure, the Board of Trustees shall use such published data as they determine appropriate and reasonable for that purpose. The Board of Trustees shall not be limited to any specific source of data but may decide that determination will be made based on a specific data source as they deem appropriate from time to time.

If the usual and customary charge for a service or supply cannot be determined because of the unusual nature of the service or supply, the Plan will determine to what extent the charge is reasonable by taking to account the complexity involved, degree of professional skill required, and other pertinent factors.

**Utilization Review.** "Utilization Review" means the prospective or concurrent review of the Medical Necessity and appropriateness of health care services being provided or proposed to

be provided to an Participant, which may be performed by either (i) the Plan Administrator or (ii) an independent Utilization Review Agent appointed by the Plan Administrator.

**Utilization Review Agent.** "Utilization Review Agent" means an independent entity that conducts Utilization Review services for the Plan Administrator.

**Vision Benefits.** "Vision Benefits" means the Benefits available in accordance with this booklet.

**Work Month.** "Work Month" means the work months adopted by the Board of Trustees for the purpose of determining eligibility in the Plan from time to time, which shall be incorporated as part of the Plan hereof.

**Workers' Compensation.** "Workers' Compensation" means the benefits provided by a State government, other public agency, an employer, or a private insurance company for injuries or occupational disease sustained in the course of and arising out of the scope of employment, and shall include, but is not limited to, all benefits provided under Chapter 4123 of the Ohio Revised Code, the Workers' Disability Compensation Act of Michigan, or other similar or analogous statute or law enacted by any state or federal government.