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 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: - Aspirin to prevent cardiovascular disease - Breast cancer prevention drugs - Iron supplementation in children - Oral fluorides for children - Tobacco cessation (one 180-day course or treatment per year) - Routine vaccinations for children & adults - 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, 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). 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). 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 Dependent Child – once every 12 months	$10 copay	Plan pays up to $35 per visit
Adult Prescription lenses – once every 24 months 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: Standard Progressive Lenses: $50 Premium Progressive Lenses: $80-90 Custom Progressive Lenses: $120-160 Avg. 35-40% off lens options.	Single vision up to $25 Bifocal lenses up to $40 Trifocal lenses up to $55 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 Frame allowance N/A

Frames, but benefit allows for frames every 12 months		
Adult Contact lenses – once every 24 months Dependent Child Contact lenses – once every 12 months – can be chosen in lieu of lenses and frames	Medically necessary: 100% Elective: up to $120 Allowance; 15% off contact lens exam (fitting and evaluation)	Medically necessary: up to $210 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. Benefits retained when you opt out: 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. Benefits retained when you opt out: Vision, Dental, EAP