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 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 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 $800 Family	

Fixed dollar copays	$20 Physician Office, $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 $3,000 Family 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% No deductible	60% after deductible up to out-of-pocket maximum; 100% thereafter.
Gynecological Exam – One per participant per year.	Covered 100% No deductible	60% after deductible up to out-of-pocket maximum; 100% thereafter.
Pap smear screening – One per participant per year.	Covered 100% No deductible	60% after deductible up to out-of-pocket maximum; 100% thereafter.
Voluntary sterilization for females	Covered 100% No deductible	60% after deductible up to out-of-pocket maximum; 100% thereafter.
Well baby and child care visits§ • 7 visits, birth through 12 months • 3 visits, 13 months through 23 months • 3 visits, 24 months through 35 months • 2 visits 36 months through 47 months • Visits beyond 47 months are limited to one per participant per calendar year under the health maintenance exam benefit	Covered 100% 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% No deductible	60% after deductible up to out-of-pocket maximum; 100% thereafter.
Fecal occult blood screening - one per participant per year.	Covered 100% No deductible	60% after deductible up to out-of-pocket maximum; 100% thereafter.
Flexible sigmoidoscopy exam- one per participant per year.	Covered 100% 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% 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% No deductible	Covered 100% 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% No deductible	Covered 100% No deductible
Smoking cessation	Covered 100% 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.		

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: - Aspirin for 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, vaginal, transdermal, IUD, implant, 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 must 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 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 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 Average 35-40% off other 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 Frames, but benefit allows for frames every 12 months	Frame allowance $170; 20% off amount over your allowance	Frame benefit $45 Frame allowance N/A
Adult Contact lenses – once every 24 months Dependent Child Contact lenses – once every 12 months -- can be chosen in	Medically necessary: 100% Elective: up to $120 Allowance; 15% off contact lens exam (fitting and	Medically necessary: up to $210 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.