

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

**Schedule of Comprehensive Major Medical**

Lifetime Plan Maximums	<ul style="list-style-type: none"><li>▪ \$2,000,000 per Covered Person except Normal Retiree (Medicare Eligible).</li><li>▪ \$500 per eye for Lasik/Vision Correction Surgery.</li><li>▪ \$500 smoking cessation, 3 attempts</li></ul>
Deductible	None
Blood Deductible (per calendar year)	3 pints
Benefit Percentage	<ul style="list-style-type: none"><li>▪ Plan pays 85% of Covered Service unless otherwise indicated until out-of-pocket maximum is reach, then 100% for the remainder of the calendar year.</li></ul>
Coinsurance Out-of-Pocket Maximum (per calendar year)	<ul style="list-style-type: none"><li>▪ \$1,500 per family; does not include Rx drugs</li></ul>
Medically Necessary	<ul style="list-style-type: none"><li>▪ Eligible Charges in accordance with this Schedule so long as they are Medically Necessary; i.e., prescribed by a physician, arise out of non-occupational accident or sickness, and do not exceed the Reimbursement amount adopted by the Trustees.</li></ul>
Prior Authorization/Pre-Certification	<ul style="list-style-type: none"><li>▪ Unless otherwise specified, Eligible Charges must be pre-approved by the applicable Utilization Review Agent. The Plan is not obligated to pay an Eligible Charge that is not approved in advance, if required.</li></ul>
<b>Eligible Charges/Covered Expenses</b>	<ul style="list-style-type: none"><li>▪ Eligible Charges for Medical Benefits include the following:</li></ul>
Hospital Expenses (inpatient)	<ul style="list-style-type: none"><li>▪ Includes medical care, services, and supplies. Subject to a twenty percent (20%) penalty for failure to obtain advance approval by Utilization Review Agent.</li></ul>
Skilled Nursing	<ul style="list-style-type: none"><li>▪ 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.</li></ul>
Hospice	<ul style="list-style-type: none"><li>▪ Eligible person 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.</li></ul>

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Rehabilitation or Convalescent Facility	<ul style="list-style-type: none"><li>▪ Facility must be<ol style="list-style-type: none"><li>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.</li><li>b) Under the full-time supervision of a physician or registered professional nurse;</li><li>c) Provides skill nursing services on a twenty-four (24) hour basis under the direction of a full-time registered professional nurse, with licensed nursing personnel on duty at all times;</li><li>d) Maintains a complete medical record on each patient; and</li><li>e) Has in effect a utilization review plan for each patient.</li></ol></li><li>▪ 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).</li></ul>
Emergency Room	<ul style="list-style-type: none"><li>▪ Accident and Acute medical emergencies incurred in an Emergency Room of a hospital or licensed urgent care clinic provided that if an Eligible Person is admitted to a hospital, the Utilization Review Agent is notified within forty-eight (48) hours of admittance.</li><li>▪ Accidents – Emergency services for accidental injuries are covered provided that services are rendered within forty-eight (48) hours after the accident and services are rendered by a legally qualified surgeon or physician in an accredited hospital or clinic.</li><li>▪ Acute Medical Emergencies – Emergency treatment covered if the condition results from the admission of the Eligible Person to a hospital within twenty-four (24) hours or sudden and/or serious symptoms which constitute a threat to the patient’s physical or psychological well being requiring</li></ul>

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<p>Emergency Room (Cont'd)</p>	<p>immediate medical attention to prevent possible permanent impairment or loss of life.</p> <ul style="list-style-type: none"> <li>▪ An injury by accident includes any injury caused by an external or violent or accidental reason and is non-occupational in nature.</li> <li>▪ \$40 co-payment is due for Emergency Room Charges. Co-payment is waived if the Eligible Person is admitted to the Hospital from the Emergency Room.</li> </ul>
<p>Blood</p>	<ul style="list-style-type: none"> <li>▪ Covered following 3 pint deductible (noted above).</li> </ul>
<p>Surgical Expenses (inpatient)</p>	<ul style="list-style-type: none"> <li>▪ Includes surgery and anesthesia charges made by a physician for surgical care and for the administration of anesthesia.</li> <li>▪ Additional charges for services rendered by additional physician or surgeons assisting the primary physician or surgeon may not exceed one-third (1/3) the cost of the primary physician.</li> <li>▪ Subject to twenty percent (20%) penalty for failure to obtain pre-approval from Utilization Review Agent.</li> </ul>
<p>Outpatient Surgery and Related Expenses; including:</p> <ul style="list-style-type: none"> <li>▪ Tonislectomy and/or Adeniodyectomy</li> <li>▪ Breast Surgery</li> <li>▪ Caesarean Section (planned)</li> <li>▪ Foot Surgery</li> <li>▪ Gall Bladder Surgery</li> <li>▪ Heart Surgery</li> <li>▪ Hysterectomy</li> <li>▪ Joint Replacement Surgery</li> <li>▪ Joint Surgery</li> <li>▪ Laminectomy</li> <li>▪ Nasal Surgery</li> <li>▪ Prostatectomy</li> <li>▪ Spinal Fusion</li> <li>▪ Surgical Treatment of Jaw disorder</li> </ul>	<ul style="list-style-type: none"> <li>▪ Includes surgery and anesthesia charges made by a physician for surgical care and for the administration of anesthesia.</li> <li>▪ Additional charges for services rendered by additional physicians or surgeons assisting the primary physician or surgeon may not exceed one-third (1/3) the cost of the primary physician.</li> <li>▪ Subject to twenty percent (20%) penalty for failure to obtain pre-approval from Utilization Review Agent. Penalty not applicable in the case of a biopsy if obtained within 7 days of procedure</li> <li>▪ Utilization Review Agent to determine if second opinion is necessary.</li> </ul>
<p>Services by Intensive Care Unit, Cardiac Care Unit, or Burn Unit</p>	<ul style="list-style-type: none"> <li>▪ Subject to twenty percent (20%) penalty for failure to obtain advance approval from Utilization Review Agent</li> </ul>

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<p>Diagnostic Services, Laboratory, X-ray, and Pathology.</p> <ul style="list-style-type: none"> <li>▪ Angiography</li> <li>▪ All Biopsies</li> <li>▪ Ultrasounds</li> <li>▪ C.A.T. Scans</li> <li>▪ MRI and MRA</li> </ul>	<ul style="list-style-type: none"> <li>▪ Subject to twenty percent (20%) penalty for failure to obtain advance approval from Utilization Review Agent. Penalty not applicable in case of a biopsy if approved within 7 days of procedure</li> </ul>
<p>Physician Charges (excluding related to mental health/substance abuse)</p> <ul style="list-style-type: none"> <li>▪ Inpatient</li> <li>▪ Office visits</li> <li>▪ Specialist Office Visits</li> <li>▪ Treatment and diagnosis of infertility</li> </ul>	<ul style="list-style-type: none"> <li>▪ Additional charges for services rendered by additional physicians or surgeons assisting the primary Physician or surgeon may not exceed one-third (1/3) the cost of the primary Physician.</li> </ul>
<p>Organ &amp; Tissue Transplants</p>	<ul style="list-style-type: none"> <li>▪ Organ transplant services and partial organ transplant services provided the Eligible Person 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).</li> <li>▪ 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.</li> <li>▪ 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.</li> <li>▪ 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.</li> <li>▪ Subject to twenty percent (20%) penalty for failure to obtain advance approval from Utilization Review Agent</li> </ul>
<p>Durable Medical Equipment</p>	<ul style="list-style-type: none"> <li>▪ Medical Equipment charges and hospital type equipment made by a person or institution, for oxygen or rental or purchase, as approved by the Utilization</li> </ul>

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	<p>Review Agent, of equipment for administration of oxygen, wheelchair or hospital-type bed, or equipment required for the treatment of respiratory problems.</p> <ul style="list-style-type: none"> <li>▪ Pre-Authorization required for equipment in excess of \$1,500.</li> <li>▪ Subject to twenty percent (20%) penalty for failure to obtain advance approval from Utilization Review Agent.</li> </ul>
<p>Treatment of Jaw Disorders – Tempromandibular Joint Dysfunction (TMJ) and Broxism</p>	<ul style="list-style-type: none"> <li>▪ No authorization required</li> </ul>
<p>Chiropractic and Acupuncture</p>	<ul style="list-style-type: none"> <li>▪ Twelve (12) visits per year without pre-approval by Utilization Review Agent, then all subsequent visits must be pre-authorized</li> <li>▪ Plan shall not be obligated to pay for Eligible Charges if Participant fails to obtain advance approval from Utilization Review Agent.</li> </ul>
<p>Home Health Care</p>	<ul style="list-style-type: none"> <li>▪ Plan shall not be obligated to pay for Eligible Charges if Participant fails to obtain advance approval from Utilization Review Agent.</li> </ul>
<p>Therapy Services</p> <ul style="list-style-type: none"> <li>▪ Chemotherapy</li> <li>▪ Radiation/Radio Therapy</li> <li>▪ Physical Therapy (after 10 visits)</li> <li>▪ Occupational Therapy</li> <li>▪ Dialysis</li> <li>▪ Respiratory Therapy</li> <li>▪ Pulmonary Therapy</li> <li>▪ Hyperbaric Therapy</li> <li>▪ Speech Therapy</li> <li>▪ Insulin Therapy</li> </ul>	<ul style="list-style-type: none"> <li>▪ Subject to twenty percent (20%) penalty for failure to obtain advance approval from Utilization Review Agent.</li> </ul>
<p>Therapy and Treatment for Pervasive Developmental Disorders or Autism Spectrum Disorder not otherwise covered under the Plan</p>	<ul style="list-style-type: none"> <li>▪ Annual benefit of up to \$4,500 for treatment and therapy prescribed by a licensed board-certified psychiatrists 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 eligible person is 12 years of age or younger and obtains advance approval from the Utilization Review Agent.</li> </ul>



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	<ul style="list-style-type: none"> <li>▪ For artificial limbs or eyes for the replacement of natural limbs or eyes.</li> </ul>
Ambulance/Transportation	<ul style="list-style-type: none"> <li>▪ Transportation of an Eligible Person 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</li> <li>▪ Local professional ambulance service for transportation of an Eligible Person to or from a hospital.</li> </ul>
Private Duty Nursing	<ul style="list-style-type: none"> <li>▪ If medically necessary</li> </ul>
Preventive Care	<ul style="list-style-type: none"> <li>▪ Medical Necessity Not Required:</li> </ul>
Well Baby Care-through Age 6	<ul style="list-style-type: none"> <li>▪ Limited frequency in accordance with the American Pediatric Association or other guidelines as recommended by Utilization Review Agent.</li> </ul>
Routine Physical Exams	<ul style="list-style-type: none"> <li>▪ Limited to Active Employees, Class 26 Employees, Indentured Apprentice, Early Retirees under the age of 60, and Journeyman-in-Training, and the spouse of any of these, provided the spouse is an Eligible Dependent.</li> <li>▪ Annually for Eligible Persons Age 35 or older, and in accordance with a schedule adopted by the Utilization Review Agent for Eligible Persons under Age 35, including Usual and Customary tests for such exams.</li> </ul>
Immunizations	<ul style="list-style-type: none"> <li>▪ Preventive immunizations prescribed and administered by a physician, limited to the flu shots and immunization injections for the prevention of mumps, measles, rubella, oral polio, diphtheria, pertussis, tetanus, meningitis, vericella (chicken pox), tuberculosis, Hepatitis B, and pneumococcal infections.</li> <li>▪ Required immunizations do not have an age limit</li> </ul>
Routine Mammograms, Pap Smear, Gynecological Exam	
Lasik Eye Surgery, Active Employee Only	<ul style="list-style-type: none"> <li>▪ Charges incurred for a Corrective Vision Procedure (as defined below) of up to \$500 per eye. Reimbursements shall be limited</li> </ul>

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	<p>to one procedure per eye and per lifetime.</p> <ul style="list-style-type: none"><li>▪ 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.</li></ul>
Smoking Cessation	<ul style="list-style-type: none"><li>▪ Up to three courses of prescribed treatment per lifetime per Eligible Person.</li><li>▪ Course of treatment is subject to applicable copayments for prescribed medication.</li><li>▪ Treatment is subject to a lifetime maximum.</li><li>▪ Reimbursement of \$500 per Eligible Person for non-prescribed treatment regardless of the number of treatments.</li></ul>
Insulin Syringes, Lancets and Test Strips	

**A) Hospitalization**

- For purposes of this Schedule, 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.
  
- Expenses 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.

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- 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.
- Claimants (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 Claimant is admitted. In the event that a medical emergency exists, certification must be obtained within 48 hours of the Claimant's admission to the hospital.
- To the extent that a Claimant 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.
- Oral Surgery. In-hospital expenses associated with oral surgery, 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.
- Limitations. Eligible Charges for hospitalization are limited by the following conditions:
  - a) The Eligible Person is admitted to the hospital by a physician or licensed dentist and is hospitalized;
  - b) 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.
  - c) Hospitalization must commence while the Eligible Person is eligible for Medical Benefit; and
  - d) If the Eligible Person would be eligible for hospitalization and treatment at any 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.

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- Termination of Eligibility. Notwithstanding the provisions of the Pre-Existing Condition Exception, should an Eligible Person have his eligibility for coverage under the Plan terminate on or after May 31, 1988, and thereafter have coverage reinstated, such Eligible Person shall be subject to the Pre-Existing Condition Exception, as defined in this Plan; provided, however, any condition for which Benefits had been paid by the Plan during previous period(s) of eligibility shall continue to be covered upon the Eligible Person's retirement.
  
- Exclusion of Injury or Illness Incurred or Aggravated in Uniformed Services. Notwithstanding any in this Plan to the contrary, should an Eligible Person 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 85% 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 Eligible Persons.

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**Schedule of Comprehensive Rx Drug Benefits**

<p>Eligible Charges</p>	<ul style="list-style-type: none"> <li>▪ Eligible Charges for Prescription Drug Benefits include any prescription if state or federal laws require one for Eligible Persons to purchase a medication.</li> <li>▪ Unless a prescription by a physician requires a brand name medication for medical reasons, Eligible Charges are limited to the Usual and Customary and reasonable cost of the generic drugs.</li> <li>▪ The amount of medication usually prescribed for the Eligible Person by the Eligible Person's Physician is covered.</li> </ul>									
<p>Timeliness of Claim</p>	<ul style="list-style-type: none"> <li>▪ Benefits are conditions upon submission to the Fund Office no later than 24 months following the date the Eligible Charge is incurred</li> </ul>									
<p>Deductible</p>	<ul style="list-style-type: none"> <li>▪ Eligible Persons shall make a co-payment to a Member Pharmacist for each prescription for up to a thirty (30) day supply filled or refilled as provided in this paragraph. Subject to a maximum of Five Hundred Dollars (\$500.00) per family aggregate co-payments for a calendar year, the amount of the co-payment per prescription shall be:</li> </ul> <table border="0" data-bbox="792 1171 1349 1312"> <thead> <tr> <th style="text-align: left;"><u>Type of Prescription</u></th> <th style="text-align: center;"><u>Co-Payment Before \$500 Maximum</u></th> <th style="text-align: center;"><u>Co-Pay After \$500 Maximum</u></th> </tr> </thead> <tbody> <tr> <td>Brand Name Drug</td> <td style="text-align: center;">\$20</td> <td style="text-align: center;">\$8</td> </tr> <tr> <td>Generic Drug</td> <td style="text-align: center;">\$10</td> <td style="text-align: center;">\$0</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>▪ After a family's co-payments have aggregated to Five Hundred and 00/100 Dollars (\$500.00) in a calendar year, the co-payment required for any prescription filled or refilled thereafter for each Eligible Person in that family until the close of the calendar year shall be in accordance with the above table.</li> </ul>	<u>Type of Prescription</u>	<u>Co-Payment Before \$500 Maximum</u>	<u>Co-Pay After \$500 Maximum</u>	Brand Name Drug	\$20	\$8	Generic Drug	\$10	\$0
<u>Type of Prescription</u>	<u>Co-Payment Before \$500 Maximum</u>	<u>Co-Pay After \$500 Maximum</u>								
Brand Name Drug	\$20	\$8								
Generic Drug	\$10	\$0								
<p>Member and Non-Member Pharmacy</p>	<ul style="list-style-type: none"> <li>▪ The Plan shall designate Member and Non-Member Pharmacies from time to time.</li> <li>▪ To obtain coverage as an Eligible Charge, Eligible Persons must present their card on each visit to a Member Pharmacist.</li> <li>▪ If Eligible Persons are unable to use a Member Pharmacy, the Eligible Person must obtain a prescription drug form from the Plan Office,</li> </ul>									

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Member and Non-Member Pharmacy (cont'd)	<p>take it to the druggist for completion, and return a completed form.</p> <ul style="list-style-type: none"><li>▪ The Eligible Person shall pay the full amount of the prescription, and be reimbursed in accordance with the Usual and Customary and reasonable Eligible Charge.</li></ul>
Injectable Drugs (must obtain prior authorization)	<ul style="list-style-type: none"><li>▪ Injectable Drugs/infusion therapy are Eligible Charges provided the Utilization Review Agents pre-approves any and all major and non-routine uses for conditions, including, but not limited to, Cancer, HIV/AIDS, Hepatitis C, Multiple Sclerosis, Rheumatoid Arthritis, migraine headaches, infertility, Crohn's Disease, growth hormone deficiency, immunosuppression, respiratory support for neomates, and hemophila.</li><li>▪ Routine injectables, such as insulin and penicillin, are Eligible Charges without advance approval by the Utilization Review Agent.</li><li>▪ Specialty Drugs are medications meant to treat specific chronic disease states and genetic condition and aimed at improving the quality of life of the patient and extending his or her life expectancy. Available in oral, injectable, and infused forms. Common disease states treated by Specialty Drugs include:<ul style="list-style-type: none"><li>a) Asthma</li><li>b) Multiple Sclerosis</li><li>c) Cystic Fibrosis</li><li>d) Psoriasis</li><li>e) Infertility</li><li>f) Respiratory Syncytial Virus (RSV)</li><li>g) Osteoporosis</li><li>h) Hepatitis</li><li>i) Growth hormone deficiency</li><li>j) Rheumatoid arthritis</li><li>k) Oncology-related conditions</li></ul></li><li>▪ A penalty of twenty percent (20%) of the Eligible Charge will be imposed for failure to obtain advance approval of the Utilization Review Agent.</li></ul>

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<p>Prior Authorized Prescriptions</p>	<ul style="list-style-type: none"> <li>▪ Injectables, all prescriptions costing \$1,500 or more per fill but must be pre authorized.</li> <li>▪ Eligible Charges include prescriptions previously authorized by the Utilization Review Agent, such as Medically Necessary medications for male impotence up to four (4) tablets per thirty (30) day period (i.e. diabetic condition causes)</li> </ul>
<p><b>Exclusions.</b> Eligible Charges do not include the following:</p>	<p>The Board of Trustees may, from time to time, provide for additional exclusions as they deem appropriate.</p>
<ul style="list-style-type: none"> <li>▪ any type of contraceptives, oral or otherwise, whether medication or device, prescribed for children for non-birth control reasons</li> </ul>	<p align="center">Excluded</p>
<ul style="list-style-type: none"> <li>▪ any payment for administration of prescription legend drugs</li> </ul>	<p align="center">Excluded</p>
<ul style="list-style-type: none"> <li>▪ therapeutic devices or appliances to include support garments</li> </ul>	<p align="center">Excluded</p>
<ul style="list-style-type: none"> <li>▪ any medication which can be legally purchased without a prescription is not covered by this Plan, not including Claritin.</li> </ul>	<p align="center">Excluded</p>
<ul style="list-style-type: none"> <li>▪ other nonmedical substances regardless of their intended use</li> </ul>	<p align="center">Excluded</p>
<ul style="list-style-type: none"> <li>▪ drugs or medication which may properly be received without charge under local, state or federal programs.</li> </ul>	<p align="center">Excluded</p>
<ul style="list-style-type: none"> <li>▪ brand drugs of which there is an acceptable generic equivalent/substitution, and the Eligible Person's Physician has not specifically prescribed a brand medication</li> </ul>	<p align="center">Plan only pays for cost of generic equivalent.</p>
<ul style="list-style-type: none"> <li>▪ medication in excess of four (4) tablets per 30-days, for medically necessary treatment of male impotence (i.e., diabetic condition caused the impotence)</li> </ul>	<p align="center">Excluded</p>

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**Schedule of Comprehensive Dental Benefits**

Preferred Provider Network	<ul style="list-style-type: none"><li>▪ DenteMax and its network of service providers has been selected as the preferred provider.</li></ul>
Deductible	<ul style="list-style-type: none"><li>▪ Unless otherwise provided, each Eligible Person must pay a deductible of twenty-five dollars (\$25) per calendar year of Eligible Charges prior to being entitled to Dental Benefits.</li></ul>
Timeliness of Claim	<ul style="list-style-type: none"><li>▪ Benefits are conditions upon submission of the Claim to the Fund Office no later than 24 months following the date the Eligible Charge is incurred.</li></ul>
Maximum Benefit	<ul style="list-style-type: none"><li>▪ Maximum benefit per Eligible Person per calendar year is one thousand two hundred and fifty dollars (\$1,250) excluding orthodontics.</li></ul>
<b>Eligible Charges/Covered Expenses</b>	Eligible Charges for Medical Benefits include the following:
Preventive (Examination and Cleaning)  Preventative Procedures <ul style="list-style-type: none"><li>▪ Examination (initial or periodic)</li><li>▪ Cleaning – Adult</li><li>▪ Cleaning – child (under age 12)</li><li>▪ Fluoride application</li><li>▪ Space maintainers – unilateral</li><li>▪ Space maintainers – bilateral (available only for individuals under age 19).</li><li>▪ Periodontic Scaling (up to 4 times per year)</li><li>▪ Periodontic cleaning (up to 3 times per year)</li><li>▪ Gingival curettage (up to 4 times per year)</li><li>▪ Sealants</li><li>▪ Emergency Examination</li></ul>	<ul style="list-style-type: none"><li>▪ 2 examinations and cleanings per calendar year. For preventive services, deductible described above does not apply</li> <li>▪ All the Preventative Procedures are payable at 100% of the provider fee schedule or the reimbursement schedule as established by the Plan.</li></ul>
Diagnostic (X-rays)	<ul style="list-style-type: none"><li>▪ Diagnostic procedures are payable as Eligible Charges; 85% of the reimbursement amount following satisfaction of the deductible.</li></ul>

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**SCHEDULE OF BENEFITS**

<p>Diagnostic (Cont'd)</p> <ul style="list-style-type: none"> <li>▪ Bitewing X-rays (1 per calendar year)</li> <li>▪ Full mouth series X-rays</li> <li>▪ Periapical X-rays</li> <li>▪ Panoramic X-ray</li> <li>▪ Diagnostic models</li> </ul>	<ul style="list-style-type: none"> <li>▪ Diagnostic Services are payable at 85% of the provider fee schedule or the reimbursement schedule as established by the Plan</li> </ul>
<p>Restorative (Filings and Crowns)</p> <ul style="list-style-type: none"> <li>▪ Amalgam restorations             <ul style="list-style-type: none"> <li>One Surface</li> <li>Two Surfaces</li> <li>Three Surfaces or More</li> </ul> </li> <li>▪ Acrylic or plastic restoration (white fillings)             <ul style="list-style-type: none"> <li>One Surface</li> <li>Two Surfaces</li> <li>Three Surfaces or More</li> </ul> </li> <li>▪ Fin retention</li> <li>▪ Gold inlay restorations             <ul style="list-style-type: none"> <li>One Surface</li> <li>Two Surfaces</li> <li>Three Surfaces or More</li> </ul> </li> <li>▪ Onlay</li> <li>▪ Inlay restoration</li> <li>▪ Crowns</li> <li>▪ Cast Post and Core (Per Crown)</li> <li>▪ Steel Post with Amalgam or Composite Build-up (Per Crown)</li> <li>▪ Recement Inlay or Crown</li> </ul>	<ul style="list-style-type: none"> <li>▪ Eligible Charges up to 85% of the reimbursement amount for the procedure following satisfaction of the deductible.</li> <li>▪ The Restorative Services are payable at 85% of the preferred provider fee schedule or the reimbursement schedule as established by the Plan.</li> </ul>
<p>Endodontics (Root Canals)</p> <ul style="list-style-type: none"> <li>▪ Pulp cap</li> <li>▪ Vital pulpotomy</li> <li>▪ Root canal therapy, including treatment plan and follow-up care (excludes restoration)             <ul style="list-style-type: none"> <li>One Canals</li> <li>Two Canal</li> <li>Three Canals s</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Eligible Charges up to 85% of the reimbursement amount for the procedure following satisfaction of the deductible.</li> <li>▪ Endodontic Services are payable at 85% of the preferred provider fee schedule or the reimbursement schedule as established by the Plan.</li> </ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

<p>Prosthodontics – Removable (Dentures)</p> <ul style="list-style-type: none"><li>▪ Complete Dentures (Upper or Lower) and 6 months post care</li><li>▪ Partial Dentures and 6 months post care</li><li>▪ Adjustments to Dentures more than 6 months after installation</li><li>▪ Denture relining (once every 36 months)</li></ul>	<ul style="list-style-type: none"><li>▪ 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.</li><li>▪ Includes initial installation of fixed bridgework, including crowns as abutments, Initial installation of partial or full removable dentures.</li><li>▪ 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:<ul style="list-style-type: none"><li>a) replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or</li><li>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</li><li>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.</li></ul></li><li>▪ Prosthodontic Services are payable at 50% of the preferred provider fee schedule or reimbursement schedule as established by the Plan.</li></ul>
<p>Prosthodontics –Fixed (Dentures)</p>	<ul style="list-style-type: none"><li>▪ 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</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

<p>Prosthodontics –Fixed (Dentures) (Cont'd)</p> <ul style="list-style-type: none"><li>▪ Bridge Pontics (All Types)</li><li>▪ Repairs –<ul style="list-style-type: none"><li>Replace broken pin facing with slotted or other facing</li><li>Replace broken facing with acrylic</li></ul></li><li>▪ Abutment Crowns (All Types)</li><li>▪ Re-cement Bridge</li><li>▪ Implants</li><li>▪ Abutment</li><li>▪ Implant Crowns</li></ul>	<p>addition of teeth to an existing partial removable denture or to fixed bridgework, but only if satisfactory evidence is presented that:</p> <ul style="list-style-type: none"><li>a) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or</li><li>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 five (5) years have elapsed since the replacement; or</li><li>c) The existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.</li></ul> <ul style="list-style-type: none"><li>▪ Also includes installation of bridgework as a replacement for dentures if the bridgework is the only means to attain a professionally adequate result.</li><li>▪ 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</li><li>▪ 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 Prosthodontic services are payable at 85% of the preferred provider fee schedule or reimbursement schedule as established by the Plan.</li></ul>
<p>Orthodontics (Braces)</p>	<ul style="list-style-type: none"><li>▪ Orthodontics are payable as Eligible Charges in an amount equal to 50% of the reimbursement amount.</li><li>▪ Only payable for a Child who is an Eligible Dependent and who is under the age of nineteen (19). Orthodontic billings incurred on or after nineteen (19) are not Eligible</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

	<p>Charges.</p> <ul style="list-style-type: none"> <li>▪ Life maximum payable per Eligible Person for orthodontics, including related extractions, x-rays and surgery is \$1,750.</li> <li>▪ 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.</li> <li>▪ Benefit payments for orthodontic services shall only be made for months during which the Participant is eligible for Dental Benefits. Benefits are paid monthly.</li> </ul>
<p>Gold, Baked Porcelain Restoration and Crowns and Jackets.</p>	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>
<p>Partial Dentures</p>	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>
<p>Complete Dentures</p>	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>
<p><b>Exclusions.</b> Eligible Charges do not include the following:</p>	<p>The Board of Trustees may, from time to time, provide for additional exclusions as they deem appropriate.</p>
<ul style="list-style-type: none"> <li>▪ Charges for services for which Benefits are otherwise provided under this Plan.</li> </ul>	<p>Excluded</p>
<ul style="list-style-type: none"> <li>▪ Charges for treatment by other than a dentist, except that scaling or cleaning</li> </ul>	<p>Excluded</p>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

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.	
<ul style="list-style-type: none"><li>▪ Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth other the ten (10) upper and lower anterior teeth.</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ Chares 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 sixty (60) days after terminations of eligibility.</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ Charges for the replacement of a lost, missing, or stolen prosthetic device.</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ Charges for a plaque control program.</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ Charges for failure to keep a scheduled appointment with the dentist.</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ Charges for replacement or repair of an orthodontic appliance.</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ 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</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ Charges for services or supplies which are not necessary according to accepted standards of dental practice</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ 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.</li></ul>	Excluded
<ul style="list-style-type: none"><li>▪ Charges for services or supplies received as a result of dental, disease, defect, or injury due to an act of war,</li></ul>	Excluded

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

declared or undeclared.	
▪ 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	Excluded
▪ Charges for any duplicate prosthetic device or any other duplicate appliance	Excluded
▪ Charges for any services to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof	Excluded
▪ Charges for the completion of any insurance forms	Excluded
▪ Charges for oral hygiene and dietary instruction	Excluded
▪ Charges for retainers, thumb guards, or other appliances used to combat oral habits. Charges for bite plates	Excluded
▪ Charges for nitrous oxide	Excluded
▪ Charges for occlusal adjustments, or other appliances necessary to increase vertical dimension or restore the occlusion	Excluded

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

**Schedule of Comprehensive Vision Benefits**

Provider	<ul style="list-style-type: none"> <li>Vision Service Plan (VSP). To find a VSP network doctor go to <a href="http://www.vsp.com">www.vsp.com</a> or call 800-877-7195</li> </ul>															
Copayments	<ul style="list-style-type: none"> <li>Ten dollar (\$10) copayment for examinations.</li> <li>Twenty-five dollar (\$25) copayment for prescription glasses</li> <li>No copayment for contacts</li> </ul>															
Timeliness of Claim	<ul style="list-style-type: none"> <li>Benefits are conditioned upon being submitted to the Fund Office no later than twenty four (24) months following the date that the Eligible Charge is incurred.</li> </ul>															
In Network /Out of Network	<ul style="list-style-type: none"> <li>Any Eligible Charges incurred by a Participants or his or her Eligible Dependents within the VSP network are covered in full subject to the applicable co-payment and limits explained below.</li> <li>Eligible Charges covered outside of the VSP network will be reimbursed in accordance with the amounts explained below.</li> </ul>															
<b>Eligible Charges</b>	Eligible Charges for Vision benefits include the following:															
Examinations	<ul style="list-style-type: none"> <li>Covered in full every 24 months if visiting a VSP network physician.</li> </ul> <table border="0"> <thead> <tr> <th></th> <th align="center"><u>In-Network Co-payment</u></th> <th align="center"><u>Out of Network Reimbursement</u></th> </tr> </thead> <tbody> <tr> <td>Exam Benefit</td> <td align="center">\$10.00</td> <td align="center">Up to \$35.00</td> </tr> </tbody> </table>		<u>In-Network Co-payment</u>	<u>Out of Network Reimbursement</u>	Exam Benefit	\$10.00	Up to \$35.00									
	<u>In-Network Co-payment</u>	<u>Out of Network Reimbursement</u>														
Exam Benefit	\$10.00	Up to \$35.00														
Prescription Lenses	<ul style="list-style-type: none"> <li>Covered in full every 24 months if visiting a VSP network physician (single vision, bifocal and trifocal)</li> </ul> <table border="0"> <thead> <tr> <th></th> <th align="center"><u>In-Network Co-payment</u></th> <th align="center"><u>Out of Network Reimbursement</u></th> </tr> </thead> <tbody> <tr> <td>Single Vision</td> <td align="center">\$25.00</td> <td align="center">Up to \$25.00</td> </tr> <tr> <td>Bifocal Lenses</td> <td align="center">\$25.00</td> <td align="center">Up to \$40.00</td> </tr> <tr> <td>Trifocal Lenses</td> <td align="center">\$25.00</td> <td align="center">Up to \$55.00</td> </tr> <tr> <td>Lenticular Lenses</td> <td align="center">\$25.00</td> <td align="center">Up to \$80.00</td> </tr> </tbody> </table>		<u>In-Network Co-payment</u>	<u>Out of Network Reimbursement</u>	Single Vision	\$25.00	Up to \$25.00	Bifocal Lenses	\$25.00	Up to \$40.00	Trifocal Lenses	\$25.00	Up to \$55.00	Lenticular Lenses	\$25.00	Up to \$80.00
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Bifocal Lenses	\$25.00	Up to \$40.00														
Trifocal Lenses	\$25.00	Up to \$55.00														
Lenticular Lenses	\$25.00	Up to \$80.00														
Frames	<ul style="list-style-type: none"> <li>Frames covered every 24 months. If frame is obtained in-network, no out-of-pocket expense other than the</li> </ul>															

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

	<p>copayment will apply. The wholesale cost of the frame cannot exceed the Wholesale Network Frame Allowance</p> <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td align="center"><u>In-Network</u></td> <td align="center"><u>Out of Network</u></td> </tr> <tr> <td></td> <td align="center"><u>Co-payment</u></td> <td align="center"><u>Reimbursement</u></td> </tr> <tr> <td>Frame Benefit</td> <td align="center">\$25.00</td> <td align="center">Up to \$45.00</td> </tr> <tr> <td>Frame Allowance</td> <td align="center">\$65.00</td> <td align="center">N/A</td> </tr> </table>		<u>In-Network</u>	<u>Out of Network</u>		<u>Co-payment</u>	<u>Reimbursement</u>	Frame Benefit	\$25.00	Up to \$45.00	Frame Allowance	\$65.00	N/A												
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Frame Allowance	\$65.00	N/A																							
<p>Contact lenses</p>	<ul style="list-style-type: none"> <li>▪ Can choose contact lenses in lieu of lenses and frames every 24 months. Allowance and reimbursement amounts:</li> </ul> <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td align="center" colspan="2"><u>Medically Necessary</u></td> </tr> <tr> <td></td> <td align="center"><u>In-Network</u></td> <td align="center"><u>Out of Network</u></td> </tr> <tr> <td></td> <td align="center"><u>Benefit</u></td> <td align="center"><u>Reimbursement</u></td> </tr> <tr> <td>Contact Lenses</td> <td align="center">100% Covered .....</td> <td align="center">Up to \$210.00</td> </tr> </table> <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td align="center" colspan="2"><u>Elective</u></td> </tr> <tr> <td></td> <td align="center"><u>In-Network</u></td> <td align="center"><u>Out of Network</u></td> </tr> <tr> <td></td> <td align="center"><u>Allowance</u></td> <td align="center"><u>Reimbursement</u></td> </tr> <tr> <td>Contact Lenses</td> <td align="center">Up to \$210.00 .....</td> <td align="center">Up to \$105.00</td> </tr> </table>		<u>Medically Necessary</u>			<u>In-Network</u>	<u>Out of Network</u>		<u>Benefit</u>	<u>Reimbursement</u>	Contact Lenses	100% Covered .....	Up to \$210.00		<u>Elective</u>			<u>In-Network</u>	<u>Out of Network</u>		<u>Allowance</u>	<u>Reimbursement</u>	Contact Lenses	Up to \$210.00 .....	Up to \$105.00
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<p><b>Exclusions:</b> Eligible Charges do not include the following</p>	<p>The Board of Trustees may provide for additional exclusions in the future as they deem appropriate. The following are excluded from this Schedule:</p>																								
	<ul style="list-style-type: none"> <li>▪ The following elective materials or services associated with lenses blended or progressive lenses, oversize lenses, special edging, tinting, coatings, and other special lens material.</li> </ul>																								
	<ul style="list-style-type: none"> <li>▪ Examinations required as a condition of employment</li> </ul>																								
	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>																								
	<ul style="list-style-type: none"> <li>▪ Commercial or safety eye glasses</li> </ul>																								
	<ul style="list-style-type: none"> <li>▪ Treatment for conditions other than refractive after the initial visit. This includes field examinations, their interpretation, and other special diagnostic procedures.</li> </ul>																								

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

**Schedule of Comprehensive Hearing Benefits**

Maximum Benefit	<ul style="list-style-type: none"><li>▪ The maximum benefit per person for Hearing Benefits is eight hundred dollars (\$800) per Limitation Period, in and out of network.</li></ul>
Limitation Period	<ul style="list-style-type: none"><li>▪ The “Limitation Period” means the thirty-six (36) consecutive month period ending with the month during which the Eligible Charge was incurred.</li></ul>
Medically Necessary	<ul style="list-style-type: none"><li>▪ The Eligible Charges set forth in this Schedule are not required to be Medically Necessary or prescribed by a physician.</li></ul>
Timeliness of Claim	<ul style="list-style-type: none"><li>▪ Benefits are conditions upon a claim being filed with the Fund Office no later than 24 months following the date that the Eligible Charge is incurred.</li></ul>
<b>Eligible Charges</b>	<ul style="list-style-type: none"><li>▪ Eligible Charges include the following services (up to the Reimbursement amount)<ul style="list-style-type: none"><li>a) Purchase or repair of hearing aids</li><li>b) Hearing examination by licensed audiologist</li><li>c) Removal of cerumen incidental to the installation of a hearing aid</li></ul></li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

**Schedule of Comprehensive Death Benefits**

Death Benefit	<ul style="list-style-type: none"> <li>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:</li> </ul>	
	<b><u>Employee Classifications</u></b>	<b><u>Amount of Benefit</u></b>
	Active Employee, Class 26, or Indentured Apprentice	\$10,000
	Early Retiree	\$2,000
	Normal Retiree	\$1,000
Accidental Death & Dismemberment (AD&D)	<ul style="list-style-type: none"> <li>In the event an Eligible Person 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 Person's employment, the following AD&amp;D benefit will be paid to the beneficiary, notwithstanding any other Death Benefit paid hereunder.</li> </ul>	
	<b><u>Nature of the Injury</u></b>	<b><u>Amount of Benefit</u></b>
	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	<ul style="list-style-type: none"> <li>Loss of Limb means dismemberment by severance at or above the wrist or ankle joint</li> </ul>	
Definition of loss of sight	<ul style="list-style-type: none"> <li>Loss of Sight means the entire and irrevocable loss of sight</li> </ul>	
Immediacy of loss	<ul style="list-style-type: none"> <li>Any loss must occur within 90 days of the accident to be covered for AD&amp;D benefits</li> </ul>	
Limitation on multiple losses	<ul style="list-style-type: none"> <li>If more than one loss covered for AD&amp;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</li> </ul>	
Exclusions	<ul style="list-style-type: none"> <li>AD&amp;D benefits shall not be payable for any loss which is:                             <ol style="list-style-type: none"> <li>Caused by or results from suicide or intentionally self-inflicted injury;</li> </ol> </li> </ul>	

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

	<ul style="list-style-type: none"><li>b) Sustained as the direct or indirect result of insurrection, war, or any act of war; or</li><li>c) 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 a commercial airports.</li></ul>
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**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

**Schedule of Comprehensive Educational Reimbursement Benefits**

<p>Primary Purpose</p>	<ul style="list-style-type: none"> <li>The primary purpose of this benefit is to provide financial assistance in the nature of scholarships for post-secondary education or vocational training to children of Eligible Employees on a uniform and nondiscriminatory basis. On a more limited basis, the benefit is intended as a means of encouraging certain Covered Employees and their spouses to further their education through certain continuing education</li> </ul>								
<p>Annual Maximum Benefit</p>	<ul style="list-style-type: none"> <li>In no event shall the aggregate Education Reimbursement benefits paid to or on behalf of an eligible person exceed the following:</li> </ul> <table border="1" data-bbox="787 779 1453 919"> <thead> <tr> <th><b>Classification</b></th> <th><b>Maximum Benefit</b></th> </tr> </thead> <tbody> <tr> <td>Covered Employee</td> <td>\$500 per year</td> </tr> <tr> <td>Spouse</td> <td>\$500 per year</td> </tr> <tr> <td>Eligible Child</td> <td>\$2,500 per year</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>When calculating annual maximum limits, the amount of benefits paid will be allocated to the year which the eligible person completed the course for which the reimbursement is made</li> </ul>	<b>Classification</b>	<b>Maximum Benefit</b>	Covered Employee	\$500 per year	Spouse	\$500 per year	Eligible Child	\$2,500 per year
<b>Classification</b>	<b>Maximum Benefit</b>								
Covered Employee	\$500 per year								
Spouse	\$500 per year								
Eligible Child	\$2,500 per year								
<p>Lifetime Maximum Benefits</p>	<ul style="list-style-type: none"> <li>In no event shall the aggregate Education Reimbursement benefits paid to or on behalf of an eligible person exceed the following lifetime maximum limits:</li> </ul> <table border="1" data-bbox="787 1283 1453 1423"> <thead> <tr> <th><b>Classification</b></th> <th><b>Maximum Benefit</b></th> </tr> </thead> <tbody> <tr> <td>Covered Employee</td> <td>\$2,500</td> </tr> <tr> <td>Spouse</td> <td>\$2,500</td> </tr> <tr> <td>Eligible Child</td> <td>\$12,500</td> </tr> </tbody> </table>	<b>Classification</b>	<b>Maximum Benefit</b>	Covered Employee	\$2,500	Spouse	\$2,500	Eligible Child	\$12,500
<b>Classification</b>	<b>Maximum Benefit</b>								
Covered Employee	\$2,500								
Spouse	\$2,500								
Eligible Child	\$12,500								
<p>Coordination of Education Benefits</p>	<ul style="list-style-type: none"> <li>Notwithstanding any provision to the contrary, in the case of a Child of 2 Covered Employees, regardless of marital status, each eligible recipient is entitled to obtain reimbursement benefits incurred with respect to such child, provided the total amount of educational reimbursement benefits do not exceed the actual expenses incurred</li> </ul>								
<p>Satisfaction of Conditions</p>	<ul style="list-style-type: none"> <li>The eligible recipient must satisfy all of the following conditions to receive Education Reimbursement Benefits</li> </ul>								

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

Condition #1 – Minimum Eligibility	<ul style="list-style-type: none"><li>▪ The eligible recipient must have been eligible under the Plan for 24 consecutive months following initial attainment of eligibility in the Plan.</li></ul>
Condition #2 – Sufficiency of Course; Courses must begin after the 24 month waiting period	<ul style="list-style-type: none"><li>▪ Completed one of the following types of courses or instruction:<ul style="list-style-type: none"><li>a) High School Education – courses that are part of the regular curriculum for attaining a high school degree (grades 9 through 12) at a private high school (only covered for a Child); or</li><li>b) College/University Education – courses provided at any accredited junior college, college or university for which credit is generally granted as part of any undergraduate or graduate degree awarded by the school (covered for any eligible recipient, provided that in the case of a Child who has attained age 19, he or she must have been a full-time student during the academic term in which the course was completed); or</li><li>c) Vocational Education – post-secondary courses at any accredited technical college or other educational institution providing vocational education or training for which credit is generally granted as part of the school’s degree program (covered only for a Child or spouse); or</li><li>d) Adult Education – continuing education or adult education courses sponsored by a college, university, or other education institution outside of a regular degree program provided that such courses do not constitute either (i) vocational education or training; or (ii) instruction in leisure or recreational activities (covered only for a Covered Employee or spouse)</li></ul></li><li>▪ Education reimbursement benefits for a Covered Employee whose eligibility is based upon his or her status as an Apprentice shall be limited to courses towards an associate degree program approved by the Toledo Education Joint Apprenticeship Training Committee or Fund.</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

	<ul style="list-style-type: none"> <li>▪ Instruction at the Toledo Electrical JATC is not considered an eligible course.</li> </ul>
<p>Condition #3 – Substantiation of Claim</p>	<ul style="list-style-type: none"> <li>▪ The eligible recipient has provided information to show the following:               <ol style="list-style-type: none"> <li>a) The course is qualified with respect to the eligible recipient;</li> <li>b) The eligible recipient has paid or incurred the cost of tuition for the course; and</li> <li>c) The course was satisfactorily completed by the eligible recipient (not less than a mark of “C” or “satisfactory or its equivalent in a course for which a grade is given) or the eligible recipient advances to the next grade in case of high school education; and</li> <li>d) The eligible recipient submits a claim for benefits to the Fund Office no later than 12 months following the date the course is completed.</li> </ol> </li> </ul>
<p>Reimbursement Amount – Educational benefits shall be payable to an eligible recipient in the following amount, but not to exceed the annual and lifetime maximum limits:</p>	<ul style="list-style-type: none"> <li>▪ High School Education – 50% of the full-time tuition for a year; payable after the school year ends.</li> <li>▪ College/University Education – \$75.00 per credit hour for a child and \$60.00 per credit hour for a Covered Employee or spouse</li> <li>▪ Vocational Education - \$75.00 per credit hour for a child and \$60.00 per credit hour for a Covered Employee or spouse</li> <li>▪ Adult Education - \$60.00 per course, up to 2 courses per year</li> </ul> <p>Notwithstanding the foregoing, in no event will the amount of benefit payable with respect to a course exceed the amount of tuition actually paid or incurred by the eligible recipient for the course</p>
<p>Year</p>	<ul style="list-style-type: none"> <li>▪ Year means the 12 consecutive month period beginning on August 1<sup>st</sup> and ending on the succeeding July 31<sup>st</sup>.</li> </ul>
<p>Discretion of Board of Trustees</p>	<ul style="list-style-type: none"> <li>▪ The Trustees may expand, reduce, or cancel the education reimbursement benefit or otherwise amend or modify the eligibility rules or reimbursement amounts. No person shall have a vested right to this benefit.</li> </ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

**Schedule of Comprehensive Personal Assistance Benefits**

Reimbursement Amount	<ul style="list-style-type: none"><li>▪ Unless otherwise provided in this Schedule, Personal Assistance Benefits shall be payable in an amount equal to eighty-five percent (85%) of the Reimbursement amount.</li></ul>
Timeliness of Claim	<ul style="list-style-type: none"><li>▪ Personal Assistance Benefits payable pursuant to this Schedule are conditioned upon the submission of a Claim for Benefits to the Fund Office no later than twenty-four (24) months following the date that the Eligible Charge is incurred.</li></ul>
Maximum Out of Pocket	<ul style="list-style-type: none"><li>▪ The maximum out of pocket expense for any Eligible Person and their family, including Eligible Dependents of the Eligible Person or persons of who the Eligible Person is an Eligible Dependent, is equal to One Thousand Five Hundred Dollars (\$1,500) per calendar year for Personal Assistance Benefits.</li><li>▪ After the maximum out of pocket amount has been reached for the calendar year, all Eligible Charges shall be fully payable as Benefits. Any out of pocket expenses incurred for Medical Benefits shall count towards the out-of-pocket expense maximum under this Schedule.</li></ul>
Maximum Lifetime Benefits	<ul style="list-style-type: none"><li>▪ Subject to same limitation as Medical Benefits. Contingent upon approval of the Utilization Review Agent.</li></ul>
Eligible Charges	<ul style="list-style-type: none"><li>▪ Eligible Charges for Personal Assistance Benefits shall include any counseling, treatment, therapy or other mental health programs prescribed, provided and approved by and through the Employee Assistance Program administered by the Mental Health Agent of the Plan.</li><li>▪ Personal Assistance Benefits may include, but are not limited to, emotional difficulties, child/adolescent issues, alcohol/substance abuse, job stress, family/marriage issues, gambling, and financial difficulties.</li></ul>
Initial Full Coverage	<ul style="list-style-type: none"><li>▪ The first three (3) visits for Personal Assistance Benefits by any Eligible Person are covered 100% of the Reimbursement amount. Additional visits are subject to regular Medical Plan Limits. Must go through Network.</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

**Schedule of Comprehensive Disability Benefits**

Conditions for Disability Benefits	<ul style="list-style-type: none"><li>▪ An Eligible Person shall be eligible to receive Disability Benefits in the event that:<ul style="list-style-type: none"><li>a) the Eligible Person becomes disabled and is unable to work because of an injury, accident or sickness</li><li>b) the injury, accident, or sickness does not arise out of or in the course of their employment entitling the Eligible Person to benefits under any Workers' Compensation or Occupational disease law.</li></ul></li></ul>
Amount of Disability Benefits	<ul style="list-style-type: none"><li>▪ The Disability Benefits shall equal thirty percent (30%) of weekly journeyman wages based upon the Journeyman (Classification 1) Wage Rate then in effect under the Inside Collective Bargaining Agreement for a forty-hour week.</li></ul>
Duration of Disability Benefits	<ul style="list-style-type: none"><li>▪ Disability Benefits shall be payable for a maximum period of twenty-six (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.</li><li>▪ Successive periods of disability separated by less than two (2) weeks of continuous active employment shall be considered to be one continuous period of disability unless they arise from different and unrelated causes.</li></ul>
Application for Disability Benefits	<ul style="list-style-type: none"><li>▪ An Eligible Person shall submit an application to the Fund Office for Disability Benefits utilizing the forms designated by the Plan from time to time.</li><li>▪ An Eligible Person applying for Disability Benefits shall provide to the Administrative Manager verification of the condition of disability as well as verification that the Eligible Person 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.</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

	<ul style="list-style-type: none"><li>▪ An Eligible Person shall submit an application to the Fund Office for Disability Benefits utilizing the forms designated by the Plan from time to time.</li><li>▪ An Eligible Person applying for Disability Benefits shall provide to the Administrative Manager verification of the condition of disability as well as verification that the Eligible Person 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.</li><li>▪ 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.</li><li>▪ 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.</li></ul>
Commencement of Disability Benefits	<ul style="list-style-type: none"><li>▪ Disability Benefits are payable to the Covered Employee as of the first day of disability if due to an accident, or as of the eighth day of a disability if due to a sickness.</li><li>▪ No disability will be considered as beginning more than three (3) days prior to the first visit to or of 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.</li></ul>
Credit of Hours	<ul style="list-style-type: none"><li>▪ In addition to the payment of Disability Benefits, a disabled Employee shall be credited with hours on the eligibility records of the Plan during the period which the disability continues for a period of at least fourteen (14) consecutive days, at the following rate:<ul style="list-style-type: none"><li>a) twenty (20) hours per week in a work month which includes five (5) weeks; and</li><li>b) twenty five (25) hours per week in a work month which includes four (4) weeks.</li></ul></li><li>▪ Notwithstanding the foregoing, no Employee shall be credited with one hundred (100) hours for more than six (6) consecutive months for any single disability. This portion of the benefit is also applicable to employment related disabilities.</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

	<ul style="list-style-type: none"><li>▪ Evidence of such occupational disability must be submitted to the Administrative Manager in order to have hours credited to the eligibility record of the disabled Employee</li></ul>
Self – Payment Continuation Rights	<ul style="list-style-type: none"><li>▪ 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.</li></ul>
Social Security Offset of Disability Benefits	<ul style="list-style-type: none"><li>▪ 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.</li><li>▪ The disabled Employee shall provide any information reasonably requested by the Plan Administrator to determine the proper amount the reduction pursuant to this Schedule XI as a condition of the payment of any Disability Benefits under the Plan.</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

**Schedule of Comprehensive Base Only Benefits**

Limitation	<ul style="list-style-type: none"><li>▪ In addition to the terms and conditions of this Schedule, all Base Only Benefits payable pursuant to this Schedule are subject to the exclusions and Utilization</li></ul>
Timeliness of Claim	<ul style="list-style-type: none"><li>▪ Base Only Benefits payable pursuant to this Schedule are conditioned upon the submission of a Claim for Benefits to the Fund Office no later than twenty-four (24) months following the date that the Eligible Charge is incurred</li></ul>
Amount of Base Only Benefits	<ul style="list-style-type: none"><li>▪ Unless otherwise provided in this Schedule, Base Only Benefits shall be payable in an amount equal to eighty-five (85%) percent of the Reimbursement amount.</li></ul>
Maximum Out of Pocket Expense	<ul style="list-style-type: none"><li>▪ The maximum out of pocket expense for any Eligible Person and their family (including whether the Eligible Person is the Eligible Dependent or has Eligible Dependents) is equal to \$1,500 per calendar year for Base Only Benefits.</li><li>▪ After the maximum out of pocket amount has been reached for the calendar year, all Eligible Charges shall be fully payable as Benefits.</li><li>▪ Out of pocket expense incurred for Personal Assistance Benefits shall count towards the out of pocket expense for Base Only Benefits.</li></ul>
Maximum Base Only Benefits	<ul style="list-style-type: none"><li>▪ All classes of Eligible Persons entitled to Base Only Benefits are limited to \$2,000,000 per person during their lifetime.</li></ul>
Medically Necessary	<ul style="list-style-type: none"><li>▪ Base Only Benefits are payable for the Eligible Charges set forth in this Schedule, provided such Eligible Charges are Medically Necessary, prescribed by a Physician, arise out of non- occupational accident or sickness, and do not exceed the Reimbursement amounts adopted by the Board of Trustees.</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

Prior Authorization / Pre-Certification	<ul style="list-style-type: none"><li>▪ Unless otherwise specified, Eligible Charges are required to be pre-approved by the applicable Utilization Review Agent.</li><li>▪ Unless otherwise provided, the Plan is not obligated to pay any Eligible Charges that are not approved in advance, if required.</li><li>▪ Health Care Professionals and an Eligible Person's family members may seek and obtain advance approval on the Eligible Person's behalf, subject to any applicable laws on the privacy of individually identifiable information.</li></ul>
<b>Eligible Charges</b>	<b>Eligible Charges for Base Only Benefits include the following:</b>
Hospital Expenses (Inpatient)	<ul style="list-style-type: none"><li>▪ Including medical care, services and supplies.</li><li>▪ Subject to a twenty (20%) penalty of the Eligible Charge for failure to obtain advance approval by the Utilization Review Agent.</li></ul>
Rehabilitation or Convalescent Facility	<ul style="list-style-type: none"><li>▪ Provided that the facility: (a) is primarily engaged in and duly licensed to provide, for compensation from its patients and on an inpatient basis, skilled nursing and physical restoration services for patients convalescing from an injury or disease; (b) is under the full-time supervision of a physician or registered professional nurse; (c) provides skilled nursing services on a twenty-four (24) hour basis under the direction of a full-time registered professional nurse, with licensed nursing personnel on duty at all times; and, (d) maintains a complete medical record on each patient, and (e) has in effect a utilization review plan for all of its patients.</li><li>▪ In no event shall the term "Convalescent Facility" include any institution, or part thereof, which is used principally as a place of rest, a place for custodial care, a place for educational care, a place for care for mental conditions, including, but not limited to, drug addiction, alcoholism, and mental retardation), or a place for the aged.</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

Skilled Nursing Services	<ul style="list-style-type: none"><li>▪ One or more of the professional services that may be rendered by a registered professional nurse or by a licensed practical nurse under the direction of a registered professional nurse.</li></ul>
Physician Restorative Services	<ul style="list-style-type: none"><li>▪ Services which assist the patient to achieve a sufficient degree of body functioning to permit self-care in the essential activities of living.</li></ul>
Hospice	<ul style="list-style-type: none"><li>▪ Hospice Care shall be an Eligible Charge provided the Eligible person obtains advance approval or a treatment plan from the Utilization Review Agent.</li><li>▪ The approved hospice care treatment shall be exclusive of and in lieu of all other Base Only Benefits under the Plan.</li></ul>
Emergency Room	<ul style="list-style-type: none"><li>▪ Eligible Charges for Accidents and Acute Medical Emergencies incurred in a Emergency Room of a Hospital or licensed urgent care clinic provided that if an Eligible Person is admitted to a Hospital that the Utilization Review Agent is notified within forty-eight (48) hours of admittance.</li><li>▪ <u>Accidents.</u> (a) Emergency services for accidental injuries are covered under the Plan provided that: (i) The services are rendered within forty-eight (48) hours after the accident, and (ii) The services are rendered by a legally qualified surgeon or physician in an accredited Hospital or clinic.</li><li>▪ <u>Acute Medical Emergencies.</u> Emergency treatment will be a covered benefit for treatment of an Acute Medical Emergency, if: (a) the condition results in admission of the Eligible Person to a Hospital within twenty-four (24) hours, or (b) Sudden and/or serious symptom(s) which might indicate a condition which constitutes a threat to the patient's physical or psychological well-being requiring immediate medical attention to prevent possible permanent impairment or loss of life.</li></ul>

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

Emergency Room (cont.)	<ul style="list-style-type: none"> <li>▪ Injury by accident is an injury caused by an external, or violent, or accidental reason, and is nonoccupational in nature.</li> <li>▪ A forty (\$40) dollar co-payment is due for Emergency Room Eligible Charges. The co-pay is waived if the Eligible Person is admitted to the Hospital from the Emergency Room.</li> </ul>
Blood	<ul style="list-style-type: none"> <li>▪ Covered as Eligible Charges following satisfaction of three (3) pint deductible per calendar year.</li> </ul>
Surgical Expenses (Inpatient)	<ul style="list-style-type: none"> <li>▪ Including surgery and anesthesia charges made by a Physician for surgical care and for the administration of anesthesia</li> <li>▪ Subject to a twenty (20%) penalty of the Eligible Charge for failure to obtain advance approval by the Utilization Review Agent.</li> <li>▪ Benefits are limited to forty-five (45%) of the Reimbursement Amount.</li> </ul>
Outpatient Surgery and Related Expenses	<ul style="list-style-type: none"> <li>▪ Including surgery and anesthesia charges made by a Physician for surgical care and for the administration of anesthesia.</li> <li>▪ Subject to a twenty (20%) penalty of the Eligible Charge for failure to obtain advance approval by the Utilization Review Agent.</li> <li>▪ Surgeon expenses are limited to forty-five (45%) of the Reimbursement amount.</li> </ul>
Services by Intensive Care Unit, Cardiac Care Unit, Burn Unit	<ul style="list-style-type: none"> <li>▪ Subject to a twenty (20%) penalty of the Eligible Charge for failure to obtain advance approval by the Utilization Review Agent.</li> </ul>
Diagnostic Services Laboratory, x-ray, pathology <ul style="list-style-type: none"> <li>▪ Angiography</li> <li>▪ All Biopsies</li> <li>▪ Ultrasounds (including obstetrical)</li> <li>▪ C.A.T. Scans</li> <li>▪ MRI and MRA</li> </ul>	Excluded
Physician Charges (excluding related to mental health/substance abuse) <ul style="list-style-type: none"> <li>▪ Inpatient</li> <li>▪ Office Visits</li> <li>▪ Specialist Office Visits</li> </ul>	Excluded

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

Organ & Tissue Transplants	<ul style="list-style-type: none"><li>▪ Organ transplant services and partial organ transplant services provided the Eligible Person 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 (aka Phase I or Pre-transplant evaluation visit). It shall be the responsibility of the patient and/or the referring physician facility to notify the Utilization Review Agent at the time of the clinical indication for organ transplantation is identified and confirmed. 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.</li><li>▪ Eligible charges include cadaveric and live donor whole organs. All transplants are subject to established guidelines for determining experimental and investigational procedures versus standard practice.</li><li>▪ Subject to a twenty (20%) penalty of the Eligible Charge for failure to obtain advance approval by the Utilization Review Agent.</li></ul>
Durable Medical Equipment	Excluded
Treatment for Jaw Disorders: Tempromandibular Joint Dysfunction (TMJ)	Excluded
Chiropractor and Acupuncture	Excluded
Home Health Care	Excluded

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

**SCHEDULE OF BENEFITS**

<p>Therapy Services</p> <ul style="list-style-type: none"> <li>▪ Chemotherapy</li> <li>▪ Radiation/Radio Therapy</li> <li>▪ Physical Therapy</li> <li>▪ Occupational Therapy</li> <li>▪ Dialysis</li> <li>▪ Respiratory Therapy</li> <li>▪ Pulmonary Therapy</li> <li>▪ Hyperbaric Therapy</li> <li>▪ Speech Therapy</li> <li>▪ Insulin Therapy</li> <li>▪ Injectable Drugs/Infusion Therapy</li> </ul>	Excluded
Home Infusion Therapy	Excluded
<p><u>Maternity:</u> Pre-Authorization Required within 30 days of pregnancy diagnosis. Dependent children are excluded from maternity coverage</p>	<ul style="list-style-type: none"> <li>▪ Subject to a twenty (20%) penalty of the Eligible Charge for failure to obtain advance approval by the Utilization Review Agent.</li> <li>▪ Maternity benefits are not 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 a 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. Enrollment required in maternity education program as approved by Utilization Review Agent.</li> </ul>
Allergy Tests and Treatments	Excluded
Oral Surgery and Oral Accidents	Excluded
Orthotics and Prosthetics	Excluded
Ambulance/Transportation	<ul style="list-style-type: none"> <li>▪ Transportation of an Eligible Person within the United States 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 to (but not back from) a hospital equipped to furnish special treatment related to such a disability.</li> <li>▪ Local professional ambulance service for transportation of an eligible person to or from a hospital.</li> </ul>
Private Duty Nursing	If medically necessary
Preventive Care	Excluded

**TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

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Well Baby Care – through Age 6	Excluded
Routine Physical Exams	Excluded
Immunizations	Excluded
Routine Mammograms, Pap Smear, Gynecological Exam	Excluded
Lasik Eye Surgery, Active Employee Only	Excluded
Smoking Cessation	Excluded

The following provisions supplement and clarify the terms and conditions for the payment of Eligible Charges as Base Only Benefits.

**Hospitalization.**

- For purposes of this Schedule III, Hospital shall mean any hospital institution which 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 by the attending physician and the Utilization Review Agent contracted by the Plan from time to time, or confirmed by Utilization Review Agent within forty-eight (48) hours in the event of emergency or urgent medical conditions requiring isolation.
- Expenses associated with Hospitalization, including anesthesia, for necessary services and supplies other than room and board. In addition, the administration of anesthetics, other than local infiltration anesthetics.
- Approval by the Utilization Review Agent must be provided in order to document the Medical Necessity of in-hospital treatment as opposed to outpatient treatment.
- Claimants (other than those eligible for Medicare) must obtain certifications for Hospitalization from any Utilization Review Agent with which the Plan contracts from time to time. Absent a medical emergency, this certification must be obtained prior to the Claimant is admitted. In the event that a medical emergency exists, certification is required within forty-eight (48) hours of the Claimant's admission to the Hospital.
- To the extent that a Claimant fails to obtain certification for a Hospitalization, then a penalty will be imposed by reducing coverage for board and room charges and miscellaneous charges to eighty percent (80%) of coverage otherwise available. This penalty is in addition to any co-payment or co-insurance provisions. The penalty does not count toward any out-of-pocket amount.

## **TOLEDO ELECTRICAL WELFARE FUND SELF-FUNDED PLAN**

### **SCHEDULE OF BENEFITS**

Oral Surgery. In-Hospital expenses associated with oral surgery, provided the Eligible Employee must submit documentation supporting the fact it was a medical necessity that the procedures be performed in a Hospital or obtain hospital pre-certification from the Utilization Review Agent with which the Plan has contracted from time to time.

Limitations. Eligible Charges for Hospitalization are limited by the following conditions: (a) The Eligible Person is admitted into a Hospital by a physician, or licensed dentist, and is hospitalized; (b) 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; (c) Hospitalization must commence while the Eligible Person is eligible for Base Only Benefits; and, (d) If the Eligible Person would be eligible for Hospitalization and treatment at any hospital operated by the United States of America, or any agency, department or unit 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 the government agency operating the same.