SUMMARY OF BENEFITS[1]

Benefit Period (Calendar Year): January 1 through December 31

For Inside Journeyman Wireman–Active Employees, Disabled Employees, Pre-Medicare-Eligible Retirees and Surviving Spouses

Medical Benefits	Network Provider	Non-Network Provider
Annual Maximum	Unlimited	
Blood Pint Deductible	3 pints	
Annual Deductible (amount you pay annually, which must be met before Plan pays benefits; 3-month carryover applies)	$300 per person $900 per family	
Coinsurance (unless otherwise noted)[2]	Plan covers 80% You pay 20%	Plan covers 60% You pay 40%
Annual Medical Out-of-Pocket Maximum (maximum amount you pay annually; including the Annual Deductible and Coinsurance you pay)	$4,300 per person $8,900 per family	$7,800 per person $15,900 per family
Physician/Office Services	**Plan Covers**	**Plan Covers**
Office Visit (Illness/Injury)	80% after Deductible	60% after Deductible
Urgent Care Facility Services	80% after Deductible	60% after Deductible
Preventive Services	**Plan Covers**	**Plan Covers**
Routine Physical Exam (limited to one per Benefit Period) – age 21 and older	100%	60% after Deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	100%
Well Child Care Services (including exam, immunizations and laboratory tests) – up to age 21	100%	100%
Routine Mammogram (limited to one per Benefit Period), covered up to 130% of the Medicare reimbursement amount; maximum reimbursement applies only to covered services received inside the State of Ohio, as mandated by the State of Ohio	100%	100%
Routine Pap Test and exam associated with Pap Test (limited to one per Benefit Period)	100%	60% after Deductible
Contraceptives and Administration	100%	60% after Deductible
Routine Colonoscopy/Sigmoidoscopy	100%	60% after Deductible

Medical Benefits Cont'd	Network Provider	Non-Network Provider
Outpatient Services	**Plan Covers**	**Plan Covers**
Surgical Services	80% after Deductible	60% after Deductible
Diagnostic Services	80% after Deductible	60% after Deductible
Physical and Occupational Therapy – Facility and Professional (limited to 40 visits combined per Benefit Period)	80% after Deductible	60% after Deductible
Chiropractic/Spinal Manipulation Therapy – Professional Only (limited to 24 visits per Benefit Period)	80% after Deductible	60% after Deductible
Outpatient Speech Therapy – Facility and Professional (limited to 30 visits per Benefit Period)	80% after Deductible	60% after Deductible
Acupuncture (limited to six visits per Benefit Period)	80% after Deductible	60% after Deductible
Cardiac Rehabilitation	80% after Deductible	60% after Deductible
Emergency Use of Emergency Room	90% after Deductible	
Non-Emergency Use of Emergency Room	80% after Deductible	60% after Deductible
Inpatient Facility Services	**Plan Covers**	**Plan Covers**
Semi-Private Room and Board	80% after Deductible	60% after Deductible
Professional Services	80% after Deductible	60% after Deductible
Maternity	80% after Deductible	60% after Deductible
Skilled Nursing Facility (limited to 100 days per Benefit Period)	80% after Deductible	60% after Deductible
Additional Services	**Plan Covers**	**Plan Covers**
Allergy Testing and Treatments	80% after Deductible	60% after Deductible
Ambulance	80% after Deductible	60% after Deductible
Diagnostic Imaging	80% after Deductible	60% after Deductible
Durable Medical Equipment (including foot orthotics)	80% after Deductible	60% after Deductible
Family Planning Exam (age 21 and over; limited to one per Benefit Period for males; 2 per Benefit Period for females)	100%	60% after Deductible
Jobst/Compression Stockings	80%; no Deductible	80%; no Deductible
Home Healthcare (limited to 100 visits per Benefit Period)	80% after Deductible	60% after Deductible
Hospice (limited to 180 days per Benefit Period)	80% after Deductible	60% after Deductible
Organ Transplants	80% after Deductible	60% after Deductible
Private Duty Nursing (excluding Inpatient)	80% after Deductible	60% after Deductible
Temporomandibular Joint (TMJ) Services	80% after Deductible	60% after Deductible

SUMMARY OF BENEFITS[1]

Benefit Period (Calendar Year): January 1 through December 31

For Inside Journeyman Wireman–Active Employees, Disabled Employees, Pre-Medicare-Eligible Retirees and Surviving Spouses

Medical Benefits Cont'd	Network Provider	Non-Network Provider
Mental Health and Substance Abuse Services	**Plan Covers**	**Plan Covers**
Inpatient and Outpatient Mental Health Services and Substance Abuse Services	80% after Deductible	60% after Deductible
	Note: Any applicable Deductible, Out-of-Pocket Maximum or Copayment corresponds to the type of service received and is payable on the same basis as any other Illness.	

Prescription Drug Benefits (In-Network Benefit Only)	Retail Network Pharmacy (34-day supply)[3]	Mail Order Pharmacy (90-day supply)[3]
Annual Prescription Drug Out-of-Pocket Maximum (maximum amount you pay annually)	$3,050 per person $5,800 per family	
Annual Deductible (amount you pay annually, which must be met before Plan pays benefits)	$50 per person	
Coverage Per Drug Type	**Plan Covers**	**You Pay**
Generic Drug	90%	$10 copay
Formulary Brand Name Drug	80%	$20 copay
Non-Formulary Brand Name Drug	60%	$30 copay
Specialty Drug	90%, 80% or 60% ($5 minimum), depending on type of drug	90%, 80% or 60% ($5 minimum), depending on type of drug

Vision Benefits[4] (In-Network Benefit Only)	Member Cost for Network Provider Services	Reimbursement for Non-Network Provider Services
Examinations		
Exam with dilation as necessary (once every 12 months)	$0 copay	N/A
Frames (once every 12 months)		
Coverage includes one pair of either contact lenses or frames and lenses	$0 copay; $150 allowance; 20% off balance over $150	N/A
Standard Plastic Lenses (once every 12 months)		
Single Vision Lenses	$0 copay	N/A
Bifocal Lenses	$0 copay	N/A
Trifocal Lenses	$0 copay	N/A
Lenticular Lenses	$0 copay	N/A
Standard Progressive	$65 copay	N/A
Premium Progressive		
Tier 1	$85 copay	N/A
Tier 2	$95 copay	N/A
Tier 3	$110 copay	N/A
Tier 4	$65 copay; 80% of charge less $120 allowance	N/A
Other vision care discounts may be available for a second pair of prescription eyeglasses or a pair of non-prescription sunglasses.		
Lens Options (once every 12 months)		
UV Treatment	$15 copay	N/A
Tint (Solid and Gradient)	$15 copay	N/A
Standard Polycarbonate – Adults	$40 copay	N/A
Standard Polycarbonate – Children Under Age 19	$40 copay	N/A
Standard Anti-Reflective Coating	$45 copay	N/A
Standard Plastic Scratch Coating	$15 copay	N/A
Polarized	80% of retail price	N/A
Photochromic/Transitions Plastic	$75	N/A
Contact Lenses In Lieu of Lenses / Materials Only (once every 12 months)		
Conventional	$0 copay; $150 allowance; 15% off balance over $150	N/A
Disposable	$0 copay; $150 allowance, plus balance over $150	N/A
Medically Necessary	$0 copay; paid in full	N/A
Laser Vision Correction (once per lifetime)		
LASIK or PRK from United States Laser Network	85% of retail price or 95% of promotional price	N/A
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used	N/A

SUMMARY OF BENEFITS[1]

Benefit Period (Calendar Year): January 1 through December 31

For Inside Journeyman Wireman–Active Employees, Disabled Employees, Pre-Medicare-Eligible Retirees and Surviving Spouses

Dental Benefits	PPO Network Dentist	Premier Network Dentist	Non-Network Dentist
Annual Maximum (applies per Benefit Period on all services, except diagnostic and preventive services, emergency palliative treatment, bitewing X-rays, brush biopsy, sealants, and orthodontic services; maximum waived for children up to age 19—except for orthodontic treatment)		$2,500 per person	
Annual Deductible (does not apply to diagnostic & preventive services, emergency palliative treatment, brush biopsy, bitewing x-rays, sealants, and orthodontic services)		$25 per person $75 per family	
Diagnostic and Preventive	**Plan Covers**	**Plan Covers**	**Plan Covers**
Exams, cleanings and fluoride treatments for dependents up to age 19 (twice per calendar year)	100%	100%	100%
Space maintainers (unlimited for dependents up to age 19)	100%	100%	100%
Emergency Palliative Treatment (to temporarily relieve pain)	100%	100%	100%
Sealants (to prevent decay of permanent teeth; once per tooth per lifetime for occlusal surface of permanent teeth for dependents up to age 19)	100%	100%	100%
Brush Biopsy (to detect oral cancer)	100%	100%	100%
Bitewing Radiographs – bitewing X-rays (twice per calendar year)	100%	100%	100%
Basic Services	**Plan Covers**	**Plan Covers**	**Plan Covers**
All Other Radiographs – other X-rays (full mouth x-rays; which include bitewing x-rays or a panorex, are payable once in any two-year period	80%	80%	80%
Minor Restorative Services (fillings and crown repair; posterior composite resin restorations)	80%	80%	80%
Endodontic Services (root canals)	80%	80%	80%
Periodontic Services (to treat gum disease; occlusal guards are payable with no limitations; root planing and scaling payable once per quadrant in 24 consecutive months)	80%	80%	80%
Oral Surgery Services (extractions and dental surgery)	80%	80%	80%
Major Restorative Services (cast restorations, including crowns and onlays and associated procedures such as cores and substructures on the same tooth, are payable once in any five-year period; metallic inlays also covered)	80%	80%	80%
Other Basic Services (miscellaneous services)	80%	80%	80%
Relines and Repairs to bridges, dentures and implants	80%	80%	80%

Dental Benefits Cont'd	PPO Network Dentist	Premier Network Dentist	Non-Network Dentist
Major Services (once in any five-year period)	**Plan Covers**	**Plan Covers**	**Plan Covers**
Prosthodontic Services (bridges and dentures; initial placement or replacement of full and partial dentures is payable at 80% once in any five-year period; bridgework limited to once in a five year period; full and partial dentures are limited to two in a five year period—the second occurrence within five years will be paid at 50%)	80%	80%	80%
Replacement of full and partial dentures (payable at 50% once within five years of payment of a denture at 80%)	50%	50%	50%
Orthodontic Services (per lifetime)	**Plan Covers**	**Plan Covers**	**Plan Covers**
Lifetime Maximum (applies for individuals under age 19 when treatment begins)		$2,500 per person	
Orthodontic Services (braces)	50%	50%	50%
Orthodontic Age Limit	Treatment must begin prior to age 19 for dependents, and coverage will continue to the end of treatment or until the maximum has been reached		

Death Benefit	Active Employee	Retiree Under Age 65
Benefit Payable	$10,000	$5,000
Accidental Death and Dismemberment Benefit	**Active Employee**	**Retiree Under Age 65**
Benefit Payable		
Life	$10,000	$5,000
Both hands or both feet	$10,000	$5,000
Sight of both eyes	$10,000	$5,000
One hand and one foot	$10,000	$5,000
One hand and the sight of one eye	$10,000	$5,000
One hand or one foot	$5,000	$2,500
Sight of one eye	$5,000	$2,500

Weekly Disability Benefit (Non-occupational Disability Only)	Active Employee
Benefit Payable	$400
Payments Begin	The 1st day of an accident, outpatient surgery or hospital confinement; or the 8th day of an illness without hospitalization
Benefit Duration	26 weeks for the same disabilities within a 24 consecutive month period

[1] The Board of Trustees has authority to change or amend the Schedule of Benefits at any time by amendment or resolution duly executed.
[2] Coinsurance expenses incurred for services by a network provider will apply only to the network coinsurance Out-of-Pocket limits. Coinsurance expenses incurred for services by a non-network provider will also apply to the network coinsurance Out-of-Pocket limits.
[3] The minimum copay per prescription is $5. This minimum applies to specialty medications and any prescriptions purchased at a participating retail pharmacy.
[4] Coverage listed applies to your first pair of prescription eyeglasses or contact lenses every Benefit Period only. Other vision care discounts are available for a second pair of prescription eyeglasses or a pair of non-prescription sunglasses. When purchased from in-network vision care providers, you get 40% off of a second pair of complete prescription eyeglasses only. You also get 20% off of a pair of non-prescription sunglasses.