Re: Changes to Out-of-Network Case Management Protocols

The Board of Trustees periodically reviews the way in which healthcare is delivered and how the state of the industry affects the Toledo Electrical Welfare Fund ("Fund") and the benefits offered by it. To best serve all participants and beneficiaries in the Fund, the Board must occasionally adjust the way in which certain benefits are administered. Therefore, the following is a summary of the adjustments the Board has determined to be in the best interests of the Fund. Unless otherwise indicated, all changes are effective June 1, 2018.

Referral to Case Managemet for Certain Out-of Network Claims

It is the Trustees' goal to provide participants with the best benefits possible. To that end, the Trustees are engaging the Fund's Case Management review agency to review certain out-of-network claims. This change allows the Fund to ensure that participants and beneficiaries are receiving the proper level of the most appropriate care at the correct facility. The Case Manager will review the diagnosis, treatment you are receiving, and the facility in which you are receiving it. This does not mean that there will necessarily be any change in your treatment plan; instead, this review simply guarantees that you are receiving the best possible care.

Inpatient Admissions

When you are admitted to a hospital or any other inpatient facility that is not in the FrontPath network, your admission will be referred to the Fund's Case Management review agency whenever that stay lasts longer than six days.

Claim Costs

Utilizing facilities and providers in the FrontPath network whenever possible provides the best quality care at the most advantageous cost for both you and the Fund. In-network providers are contractually obligated to provide care at a reasonable, negotiated price. Out-of-network providers are under no such obligation. Therefore, the Fund's Case Management review agency will review all out-of-network claims under the following circumstances:

- Whenever a claim exceeds 250% of the FrontPath reimbursement amount, it will not be a covered benefit until it goes through the claims review process through Case Management.
- Whenever any single claim or any course of treatment exceeds $10,000, that claim or course of treatment will be referred to Case Management.[1]

You may contact the Fund Office at 419-666-4450 if you have any questions about this Summary of Material Modifications, or any other questions about your benefits under the Fund.

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[1] This threshold does not apply to emergency admissions, except to the extent allowed by the Patient Protection and Affordable Care Act.