CANTON ELECTRICAL WELFARE FUND

Office Location
33 Fitch Boulevard
Austintown, Ohio 44515

Phone: (330) 270-0453
Toll Free: (800) 435-2388

April 1, 2014

Dear Participant:

It is Open Enrollment time of year, again. As you are aware, the Canton Electrical Welfare Fund offers you the choice of two separate Claims Payors. You and your dependents have the right to elect to have your medical claims paid by either Medical Mutual of Ohio (MMO) or Aultcare. Enclosed you will find a Summary of Benefits and Coverage (SBC) form outlining the Plan's Schedule of Benefits. The benefits provided are the same whether you choose MMO or AultCare. Both of the Claims Payors offer what is called a Preferred Provider Organization or PPO which means the Plan will pay different levels based on whether you use a network or non-network provider. The PPO system, if used properly, will save the Fund money, which will hopefully allow the Trustees to provide you and your families with better medical benefits. However, in order to use the system properly, you and your families should use the "In-Network" providers of your chosen PPO. If you use an "Out-of-Network" provider, the Fund will not receive the full discounts on services and you will be subject to higher deductibles, co-insurance and any charges over the Traditional or Usual, Customary, and Reasonable Amount (UCR). Everyone benefits when you and your family use "In-Network" hospitals and doctors.

You will need to review the SBC and each Claims Payor's network to decide which Plan is best for you and your family for the upcoming year. If you are happy with your current Claims Payor, you do not have to complete any information at this time. On June 1, your coverage through the current Claims Payor will not change. **However, if you wish to change Claims Payors, you must complete the Application Form enclosed for the new Claims Payor and return it to the Fund Office by May 15 in the enclosed self-addressed envelope.**

Once your new Claims Payor has processed the application, you and your dependents will receive new identification cards. As of June 1, you will only be able to have your claims paid by your new Claims Payor. If you have any outstanding bills prior to June 1, and you have elected to change Claims Payors, you need to inform your doctor or hospital that those bills are still to be processed by your old Claims Payor. For all medical services you receive on or after June 1, you need to let your doctors or hospital know that you have a new Claims Payor and present your new card.

For example, if you decide that Medical Mutual of Ohio does not cover your primary care doctor and Aultcare has your doctor in their network, you can change your coverage to Aultcare **only** if you complete the Aultcare Application included with this letter and forward it to the Fund Office by May 15. In May, you visit your doctor. You would need to have that bill submitted to Medical Mutual of Ohio because they are still your Claims Payor until June 1. Then, on June 10, you have to visit the doctor again. At this second visit, you need to present your new Aultcare identification card and have the second visit billed to Aultcare.

THE FOLLOWING ARE ANSWERS TO SEVERAL CONFUSING AND FREQUENTLY ASKED QUESTIONS RELATING TO CLAIMS PAYORS:

Q. 1. If I have a question regarding my medical care benefits, who can I call?

A. You will contact your own Claims Payor's Customer Service Department for information on your medical benefits. If you have selected Medical Mutual of Ohio as your Claims Payor, you will need to call (800) 540-2583. If you have selected Aultcare as your Claims Payor, you will need to call (330) 363-6360 or (800) 344-8858. If you have any general questions about your benefits with the Fund, you can always call the Fund Office at (330) 270-0453 or (800) 435-2388.

Q. 2. How do I know if my doctor or hospital is "In-Network" for my Claims Payor?

A. You can either call the Customer Service Department of either Medical Mutual of Ohio or Aultcare listed above to determine whether your doctor or hospital is "In-Network" or access their website at www.medmutual.com for MMO or www.aultcare.com for AultCare. There are situations, where a doctor may work in an "In-Network" Hospital, even though they are not part of the Claims Payor's Network. You should make every effort to confirm that your provider is part of your Claims Payor's network prior to having a service performed. However, the Fund understands that in certain situations this is not possible. Accordingly, you need to contact your Claims Payor when these unfortunate situations occur and follow their instructions.

The MMO Network has several doctors and service providers that work with "In-Network" Hospitals, but that are classified as "Out-of-Network". Consult your directory and if you have any questions, call Medical Mutual.

The Aultcare Network has contracts with all of their "In-Network" Hospitals which requires all doctors and service providers, like radiology, anesthesiology, etc., which work in their hospitals to also become part of their network. If the doctor or service provider is not listed in the Aultcare directory, that doctor or service provider is "Out-of-Network".

Q. 3. Can I still go to my doctor even if he/she is not considered "In-Network"?

A. Yes. You can always choose your own doctors and other medical providers. However, as explained in this letter and the attached SBC, you may be responsible for more out-of-pocket costs if you go to a doctor or hospital that is not listed in your Claims Payor's Network. Depending upon the service you are receiving, you may be responsible for deductibles, co-insurance and payments over UCR.

Q. 4. Can my doctor refer me to an "Out-of-Network" doctor?

A. Yes. However, if an "Out-of-Network" doctor treats you, you should understand that part of the cost of that doctor's services might have to be paid by you.

Q. 5. What happens if my "In-Network" doctor refers me to an "Out-of-Network" doctor for services?

A. You may choose to accept your doctor's referral to the "Out-of-Network" doctor; however, you will not receive the "In-Network" level of benefits. **In other words, you will be responsible for**

the deductibles, co-insurance and UCR charges like any other "Out-of-Network" service that you receive as outlined on the SBC Form included with this enrollment package. However, if you are referred out of your network, you should contact your Claims Payor directly, prior to receiving the medical services, in order to discuss your alternatives.

Q. 6. What happens if I use an "Out of Network" hospital for services?

A. You may choose to use an "Out-of-Network" hospital; however, you will not receive the "In-Network" level of benefits. **You will be responsible for any excess charges, deductibles, or co-insurance that may apply as outlined on the SBC Form included with this enrollment package. You should contact your Claims Payor directly, prior to receiving the medical services, in order to discuss your alternatives.**

Q. 7. What is this "UCR" and why am I liable for over-UCR payments to my doctors when I have medical insurance?

A. UCR is a term used by all medical insurance providers, including your Claims Payors, that means "Usual, Customary, and Reasonable Charges", which are the normal fees charged by a healthcare provider in a particular geographic area for the type of service provided. The Fund will not pay medical charges, which are in excess of the UCR. In other words, UCR provides a check on the medical profession billing practices due to the fact that it does not allow one doctor in an area to overcharge for the same procedures because it compares the doctors to one another.

For "In-Network" Doctors, charges for medical services are negotiated between your Claims Payor and the service provider. The Fund pays these charges at the established rate, so an "In-Network" doctor will not have any over-UCR charges.

For "Out-of-Network" doctors, charges above UCR will normally not be covered by the Fund. **If the doctor does not have a contract with your Claims Payor, you will be responsible for the charges exceeding the UCR. You should contact your Claims Payor directly, prior to receiving the medical services, in order to discuss alternatives.**

For Example, if an "Out of Network" doctor charges $100.00 for an office visit and the Usual, Customary, and Reasonable Charge for that visit, as determined based upon all doctors fees in the area is only $75.00, then your Claims Payor will pay $48.75 (services are reimbursed at 65% of UCR) assuming that you have met your deductible limits. You will be responsible for the $51.25 difference.

Q. 8. If I enroll with a new Claims Payor, will my medical benefits change?

A. No. Each Claims Payor processes benefits according to the SBC included with this enrollment package. **This does not mean that you will receive the same payment of benefits, because your NETWORK will change if you change Claims Payors.** There is a chance that a physician or service provider prior to changing your Claims Payor would be "In-Network" and services provided by him would be paid in full. Then after you change Claims Payors that same provider would become "Out-of-Network" and the services provided would be paid at the "Out-of-Network" benefit level and you would have an out-of-pocket expense.

For Example, if you were with Medical Mutual of Ohio and you receive allergy testing from a specialist that is in the MMO Network, you would receive benefits paid at 85%. You then change your enrollment to Aultcare on June 1 and your specialist is an "Out-of-Network" doctor because he/she is not part of the Aultcare Network. On your next visit for allergy testing, you will only have the benefits paid at 65% of UCR and you will be responsible for 35% out-of-pocket. In addition, you could be billed by the specialist for the over-UCR cost which may exist.

The Board of Trustees is trying to give you as much information as possible to aid in your decision regarding your Claims Payor; however, we cannot always anticipate every situation which may occur that will cause confusion over your medical benefits. Accordingly, if you have any specific questions which are not listed here, please contact the Claims Payors or Fund Office at the number listed above to discuss your questions

If you have any questions about this notice, please contact the Fund Office at the address and telephone number listed on page 1 of this notice.

Sincerely,

BOARD OF TRUSTEES
CANTON ELECTRICAL WELFARE FUND

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan mean that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator, 33 Fitch Blvd., Austintown, Ohio 44515. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.