



CURRENTS

SAN DIEGO ELECTRICAL TRUSTS

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PPO PLAN "BUNDLED PRICING" OUT-PATIENT SURGERY PROGRAM \$0 OUT-OF-POCKET COST

The Board of Trustees of the Health & Welfare Trust has entered into an Agreement with Global One Ventures ("G1") that will greatly reduce the overall cost of a multitude of out-patient surgical procedures ranging from knee/hip replacement to cataract lens replacement procedures by arranging a single "bundled price" consisting of all fees for the facility, surgeon, anaesthesiologist and a replacement device (when applicable) that will total far less than if each service provider billed the Plan for their services separately.

The program is designed to encourage surgeries to be performed in high quality, lower cost outpatient facilities rather than hospital settings. Some bundled prices are 50% or more lower than if they were billed by the same service providers under their PPO network fee arrangements.

The PPO plan now provides that any procedure performed in accordance with a G1 bundled program will be covered by the Plan at 100%, meaning there would be \$0 in cost to the participant for the procedure. Further, depending on the procedure to be performed at one of the G1 network facilities

the participant may receive a savings bonus payment for utilizing their facility.

For example - The Plan's limitation for just the facility and replacement joint charge for a knee or hip replacement is \$30,000 (even though billed PPO hospital charges in San Diego can exceed \$90,000). The bundled price for a hip replacement performed at one of G1's facilities is presently \$22,500 and that includes the services of the surgeon and anaesthesiologist. Alternatively, the first case processed under this program was for a cataract lens replacement including an optional state-of-the-art laser incision that is routinely not covered as part of the standard cataract replacement procedures and may cost as much as \$1,750 out-of-pocket per eye. The bundled price, including the laser incision, paid by the Plan at 100% was only \$ 6,250 with \$0 paid by the participant.

There are presently 4 network surgi-centers in San Diego County, each with a list of surgeons who are willing to work under this bundled pricing approach with G1, some of whom are Sharp and

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"HEAL" IN-HOME PPO PHYSICIAN VISITS FOR ONLY \$5

The Board of Trustees has approved a new program whereby PPO Plan participants within most portions of San Diego County may arrange for a physician to come to their home instead of trying to get into a physician's office or enduring the wait (and expense) at an urgent care facility or even a Minute Clinic for the treatment of routine, non-life threatening medical issues.

To be considered is the length of time it may take to get an appointment to see a doctor and the average emergency room wait time can be many hours **(from 2 hours 45 minutes to over 4 hours in San Diego)**, adding

that it is reported that a high percentage of ER visits are unnecessary. At the same time, plan sponsors and their participants experience the pain of dealing with the high cost of the health care delivery system in addition to incurring higher costs derived from lost productivity for sick days, avoidance of voluntary health measures and abuse/overuse of emergency rooms & urgent care services. "Heal" is an in-network PPO program presently operating in San Diego, Orange County, Los Angeles and the Bay Area that is designed to provide convenient, affordable, proactive and personalized preventive, primary and urgent healthcare in the home at the Anthem

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CHANGE IN PPO PLAN MENTAL HEALTH/ SUBSTANCE ABUSE PROVIDERS AS OF JANUARY 1, 2017

Please be advised that effective January 1, 2017 Optum will replace MHN as the PPO Plan's **EXCLUSIVE** provider of mental health/substance abuse coverages. This will include both out-patient and in-patient services for which Optum will make available a network of service providers throughout San Diego and Imperial Counties. However, all acute hospital care and residential treatment will be provided in San Diego County.

In fact, Optum will be contacting any MHN provider who is treating a participant of this Plan to address continued treatment post-January 1, 2017. Every effort will be made to arrange continuity of treatment to include offering a service provider who is not a network provider at the time to join Optum's network. Should that not occur then arrangements will be made to permit continued treatment for a specified period of time.

Recognizing that MAP is available to covered participants of Plan A and B for up to 8 confidential visits each 12-months **at no out-of-pocket cost** it is important for all Plan A PPO participants to be aware that this program will be available with benefits and cost sharing per the same Schedule of Benefits as for medical services.

One very important thing to be aware of is that use of a out-of-network provider (therapist, hospital or residential facility) will result in payment by the Plan of only 60% of what would have been paid if a network provider had been utilized and the participant will be exposed to covering the full balance due between what the Plan paid and what the service provider billed. Further, there would be no point in time after satisfying the \$1,750 out-of-pocket maximum applicable to Anthem network providers for that calendar year that eligible expenses will be payable at 100% of the maximum

allowable charge.

For anyone requiring mental health/substance abuse services between now and December 31, 2016 please be sure to use only MHN network service providers and facilities to avoid substantial out-of-pocket cost exposure. Thereafter, as of January 1, 2017, it is imperative that when seeking services for a mental health/substance abuse issue that the participant (or their family) make sure you are using either MAP or one of Optum's network of service providers and facilities. As of January 1, 2017, if there is ever a question as to whether a service provider or treatment facility is a member of the Optum network the participant should contact Optum directly or your claims examiner in the Trust Office (x-702).

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in-network rate. **For covered services under the PPO Plan there will only be a \$5 co-pay for the physician visit**, the visit cost for non-covered services will be \$99. As a reminder, the Minute Clinic fee for a visit with a physician's assistant is \$79 with a \$10 co-pay and the co-pay for a Sharp physician office visit is also \$10.

There are over 75 credentialed family practice, internal medicine and pediatric physicians in their program coming from schools such as Harvard, UCLA, USC, Stanford, Columbia, UCSF and Michigan. The way the program works is that a participant may call from any phone to arrange for an in-home visitation that will expectedly occur within 2 hours from the call unless a later specific time or alternate location is established during the call. Presently the

average wait time in San Diego is just under an hour.

There is also a smart phone app that would allow a participant to create an account, immediately determine if a network physician is available in their area, enter their address with any specific instructions, such as which house, apartment building or unit they are in, complete a patient profile, identify their insurance plan, scan their insurance card, confirm the visit, track future appointments as well as the physician's progress in reaching their destination.

This service is available **daily from 8 am - 8 pm** and offers a wide array of services including well child exams for school, sports physicals, chronic disease management, common ailments (such as

infections of the eyes, ears, nose, throat, bronchial as well as colds, flu, allergies, GI issues, sports injuries), procedures (such as laceration repair, suture removal, joint injections), point of care testing (such as pregnancy test, flu test, blood glucose test), and follow-up visits. It is also possible to ask medical questions through the <https://heal.com/about-heal> web site. **This service would seem to be a terrific convenience for mothers with young children.**

Give it a try by accessing <https://heal.com> or call 1-844-644-HEAL (4325). If there are any questions about the program please contact your claims examiner (x-702).

SPECIAL ENROLLMENT OF DEPENDENTS UNDER HIPAA

Under HIPAA group health plans are required to provide special enrollment periods during which a dependent of a covered participant who was not previously covered under Plan A or Plan B for health coverage may be enrolled subject to a timely enrollment and the dependent satisfying the eligibility requirements of the Plan.

A special enrollment may be possible upon the occurrence of one of the following events:

1. A dependent loses eligibility for coverage under a group health plan or their employer ceases contributing toward their coverage;
2. An individual becomes a new dependent through marriage, birth, adoption or being placed for adoption; or
3. An individual loses coverage under a State Children's Health Insurance Program (CHIP), Medicaid/Medi-Cal or becomes eligible to receive premium assistance under programs for group health plan coverage. A request for enrollment on this basis only must be filed within 60 days of the loss of coverage.

However, it is important to note that under the first two events the dependent must notify the Trust Office of their intent to request enrollment within 30 days after their coverage ends or after the employer stops contributing toward their

other coverage. Notification after 30 days may result in the loss of enrollment entitlement until the next open-enrollment period conducted in October of each year for coverage to become effective the following January 1st.

In order to request a HIPAA special enrollment the participant must complete the following steps:

1. Submit evidence as to the date of, and reason for, termination of coverage or contribution cessation.
2. Complete an updated enrollment card, if necessary.
3. Complete a new Plan A or Plan B Kaiser application, if applicable.
4. Completion of the HIPAA Special Enrollment Form available through the Trust Office.

Please be aware that any approved dependent enrollment is limited to the existing Plan A or Plan B coverage in effect for the covered participant as no change from their current Plan A or Plan B coverage may occur (so long as it is permitted by the Plan) until the next open-enrollment period which provides coverage effective the following January 1st.

Should there be any questions please contact the Trust Office (x-310 or 702).

BE AWARE OF PPO PLAN COVERAGE FOR CHILDREN SPORTS ACTIVITY INJURIES

For parents with children participating in organized sports activities it is extremely important to be aware that the PPO Plan has specific provisions with respect to "Student Accident Insurance" in the form of any individual or group insurance policy covering a Dependent Child for an accident, injury or an event requiring immediate and/or future medical services.

When a Dependent Child participates in sporting events the scope of this provision will recognize their participating in, practicing for, and/or traveling to/from any organized individual or team sporting event while representing an educational institution and/or to any individual or group insurance policy covering a Dependent Child participating in an All-Star or traveling sports team that may not be representative of, or sponsored by, an educational institution.

Further, if an insurance policy covering an automobile or any other craft or vehicle, including air or water craft, or a Student Accident insurance policy, provides that coverage for medical expense benefits is applicable on an "excess" basis only then there would be no benefits payable by this Plan until such time as the maximum amount of medical expense benefits payable under each policy have been paid.

If there are any questions as to how Student Accident Insurance will be recognized under the Plan please contact your claims examiner at the Trust Office (858-569-6322 or 800-632-2569, x-702).

PPO PLAN CONTRACEPTIVE CLAIM PRICING

Under the PPO Plan it is very important for female participants to be aware of how covered contraceptive drugs and devices are priced in order to avoid a surprise large out-of-pocket cost.

Basically, contraceptives drugs are payable at 100% subject to a maximum of \$55 for a 30-day supply or \$165 for a 90-day supply. This means that any portion of the cost of a 30 or 90 day supply exceeding the \$55/\$165 maximum, whether the medication is purchased directly at a pharmacy or via mail-order, will have to be paid by the participant. Further, contraceptive devices are also covered at 100% up to a maximum of \$1000 maximum which means any portion of the cost of a contraceptive device exceeding \$1000 will have to be paid by the participant. The only exception to this payment maximum limitation is if a particular contraceptive medication or device is the only one of its kind in a particular classification of contraceptive medication/device.

In most cases there are multiple alternatives with regard to birth control pills and contraceptive devices that cost less than their respective maximum payable amounts. However, if any participant wants a higher cost

contraceptive drug or device they are welcome to purchase them with the understanding they must pay the portion of the cost exceeding the Plan limitation.

Example: For 2016 Sharp Rees-Stealy more than tripled its 2015 charge for a Mirena IUD up to \$2092 (by simply changing its billing code) of which about \$2063 would be allowed as eligible expense under the Plan. However, when applying the Plan maximum of \$1000 the participant would be responsible for the remaining \$1063.

The important fact is that (along with birth control pills costing less than \$55/\$165) there are IUD's that cost less than \$1000 and there are numerous sources other than Sharp Rees-Stealy from whom to purchase them at prices ranging between \$500 - \$800. **If there is ever a question as to whether the Plan will pay for a particular birth control pill or contraceptive device at 100% please call your claims examiner at the Trust Office (x-702) before making the purchase in case there may be a need to get a new prescription for a different medication or device.**

PPO PLAN REDUCED OUT-OF-POCKET COST PROGRAMS

The following are PPO programs available to covered participants at **little or \$0 out-of-pocket costs** for eligible expenses:

Best Doctors - **\$0 cost** to access Best Doctors to have difficult diagnoses/treatment plans validated, seeking a referral to an expert physician or ask medical questions. If a complete "Inter-Consultation" is performed there will be a **refund or waiving of the \$250 deductible** for that year and/or **\$0 out-of-pocket cost** if before one of a list of or specified elective surgical procedures. **Call 1-866-904-0910.**

Pinnacle - **\$0 out-of-pocket cost** for eligible medical and dental services rendered only by Pinnacle network providers in Mexico. Call 1-760-355-3943, ext 7343.

Global One Ventures - **\$0 out-of-pocket cost** for procedures performed at a

network out-patient surgi-center. There may also be a **savings payment of \$250 or \$500** to the participant for having their procedure performed at a participating out-patient surgery facility. Call 760-494-9208.

"Heal" (This is new!) - \$5 co-payment for an in-home physician visit routinely provided within 2 hours of making an appointment by phone or via smart phone. Avoid long waits to schedule a physician office visit or many hours waiting at an urgent care/emergency room. **This program is recognized as a network provider in the Anthem PPO.** Call 1-844-644-4325 Hours are from 8:00 am - 8:00 pm Monday - Sunday.

Please contact your claims examiner at the Trust Office (858-569-6322 or 800-632-2569, x-702) with questions as to any of the above programs or the PPO Plan in general.

WEEKEND AND OFF-HOUR DRUG TEST COLLECTION FACILITIES

In response to comments received by the Trust Office and Union Hall as to the availability of test collection sites during off-business hours or on a weekend please be advised of the following authorized testing facilities that are open at other than normal business hours between 8 am to 6 pm on Monday through Friday each week. They are: US Healthworks, 5575 Ruffin Rd, San Diego, CA 92123 **(Daily 6 pm - 6am ONLY)**; South Coast Medical Clinic, 408 W. 8th St, National City, CA 91950 **(M-F 7:30 am -7:30 pm, Sat 7:30 am-5 pm/Sun. 7:30 am - 2 pm)**; East County Urgent Care, 1625 E. Main St, El Cajon, CA 92021 **(Sat/Sun 9 am - 2:30 pm)**; Work Partners Occupational Health Services, 2365 S. Melrose Dr., Vista, CA 92081 **(M-F 9 am - 9pm, Sat/Sun 9 am - 5pm)**; Work Partners Occupational Health Services, 2122 S. El Camino Real, Oceanside, 92054 **(Sat/Sun 9 am - 2pm)** and Inland Valley Urgent Care, 36320 Inland Valley Dr., Wildomar, CA 92595 **(Daily 9 am-9 pm).**

Please remember that it is each employee's responsibility to complete their "Birthday" test at any time during their birth month regardless of whether or not a reminder notice was received from the Medical Review Office. Further, any employee whose clean-card status under the NECA/IBEW Drug-Free program becomes invalid must work through the MAP to be authorized to take a test to reinstate their clean-card.

For a list of all collection sites and operating hours please contact the Trust Office (x-310).

NEW TRUSTS WEB SITE REGISTRATION COMING SOON

For the past few months, the Trust Office has undertaken a major project of revamping the Trust's website (www.569trusts.org) to become more user friendly and interactive. As phase I nears its completion, participants will soon be able to register utilizing a personal email address and creating a password. Access to the site under a secured login will provide participants with the ability to see their work history along with their eligibility for health insurance. Participants will also be able to utilize the pension benefit estimator which will show current pension benefits earned as well as their different benefit option choices. The pension estimator will also allow participants to project future pension benefits based upon estimated future hours worked.

As previously provided, the site contains access to each Trust's Plan Documents including the current Summary Plan Descriptions (SPD). Links to the service providers for whom the Trusts are contracted with are also provided. Clicking on these service provider links will take you to that organization's website. Important articles relating to any of the Trusts, which also appear

in the "CURRENTS" newsletters, are displayed on the website's home page.

Phase II is underway which will allow participants to access most forms/documents/applications, as well as completing various forms/documents/applications and eventually submitting them online. Another benefit that will be provided in Phase II is the ability for participants to opt into electronic communications (emails). Plan changes and updates will then be communicated through email for those participants who opt-in. Included with those communications will be the ability for participants to receive their Explanation of Benefit (EOB) forms online along with a history of their claims.

Current participants may go to www.569trusts.org to see the layout of new website. Certain documents are currently available and those options not currently available will appear as under construction. The Trust Office expects registration to be available by late-October 2016. Please pay attention to correspondence coming soon from the Trust Office providing participants with guidance as to how to register for the new website.



BEST DOCTORS SAVES LIVES

It has been reported by the Best Doctors program that in their 27+ years of experience of reviewing self-reported medical cases **20+% of diagnoses** are clarified or changed, **60+% of recommended treatment plans** are clarified or changed, **38% of all recommended surgeries** are totally unnecessary and **another 18%** of recommended procedures would not be the best one for the patient.

The Best Doctors program is available to all Covered Persons in the Plan A PPO Plan and all Kaiser Plans (Plans A, B & C). Under the PPO Plan there are certain incentives for participants who contact Best Doctors and complete the "Inter-Consultation" process. For Plan A PPO Covered Persons their calendar year deductible will be waived. Further, for services performed by and at a PPO Provider, all Eligible Expenses pertaining to the performance of any of the following elective surgical procedures will be paid at 100% (with no out-of-pocket cost) if a Best Doctors "Inter-Consultation" is completed **before** the procedure is performed: **back, hysterectomy, knee and hip replacement, obesity or bariatric, coronary artery by-pass graft, heart valve replacements, prostatectomy and lumpectomy/mastectomy.**

To qualify for payment of all Eligible Expenses related to the elective surgical procedure at 100% a Certification of Completion of a Best Doctors "Inter-Consultation" conducted prior to the date the procedure is performed must be received by the Plan. However, there shall be no requirement

that the Best Doctors "Inter-Consultation" findings must be followed by the Participant or their physician in order to qualify for this incentive subject to application of any other Plan limitations. In the event Best Doctors determines that an "Inter-Consultation" is not necessary, this incentive shall not apply.

If you receive a recommendation for one of these specified elective surgeries from a physician, or any other significant surgical procedure or medical diagnosis for that matter, please **contact Best Doctors at 1-866-904-0910**. Please remember you must be covered under Plans A, B or C at the time in order to qualify to receive the Best Doctors services offered by the Plan **at no cost to the participant**.

BEST DOCTORS HELPS TO SAVE LIVES AND CONTRIBUTE TO PARTICIPANTS ACHIEVING OPTIMAL MEDICAL OUTCOMES BY PREVENTING UNNECESSARY, IMPROPER OR INAPPROPRIATE TREATMENT. ADDITIONALLY, OVER THE LAST 5 YEARS PARTICIPANTS AND THE PLAN HAVE SAVED HUNDREDS OF THOUSANDS OF DOLLARS IN CLAIM COSTS WHICH HELPS TO KEEP THE HOURLY CONTRIBUTION RATE AS LOW AS POSSIBLE.

If there are any questions please contact the Trust Office (x702).

2017 ANNUAL INFORMATION UPDATE MUST BE RETURNED TO AVOID COVERAGE VERIFICATION AND CLAIMS DELAYS

REMINDER! Now that the Fall open-enrollment season for group medical coverage to be effective for 2017 is coming to an end all Plan A participants are required to complete and return the "lavender purple" Annual Information Update Form, in particular reflecting any change with respect to dependent group medical coverage to be effective as of January 1, 2017, to be sent out with a self-addressed, stamped return envelope.

Completing and returning this Form to the Trust Office as soon as possible will prevent any delay in verifying dependent coverage or processing PPO Plan claims for services rendered on or after January 1, 2017. This Form contains basic claim form information necessary to permit the Trust Office to maintain accurate eligibility and PPO Plan related data.

VERY IMPORTANT - the Annual Information Update Form contains specific questions as to whether a spouse may work and/or have access to

group medical coverage of their own. In the event a spouse has **available to them** a group medical plan for which the cost to the spouse would be \$100 or less per month, or in the event a spouse would receive any compensation whatsoever for declining or waiving available group medical coverage, the Plan is very specific to the extent the spouse will be ineligible for group medical coverage under the Plan. However, in the event of such an exclusion a spouse may still be eligible for Plan A dental and vision benefits.

When completing this Form please pay careful attention to the dependent spouse group medical coverage addressed above as there are specific time constraints under federal law to the extent a spouse may want or need to try to re-enroll in their own plan upon learning they had become ineligible under this Plan as far back as the beginning of the year.

Please direct any questions at this time to the Trust Office (x702).

MEMBERS' ASSISTANCE PROGRAM ("MAP") WELLNESS PORTAL

As a reminder, covered Plan A and Plan B participants (employees and dependents) are eligible for up to 8 confidential MAP sessions within a 12-month period at no out-of-pocket cost. In addition, the Plan's MAP service provider, Aetna Resources For Living, has developed a free 24/7 wellness portal

"myStrength", that may be accessed at <https://www.mylifevalues.com>.

You may use "san diego electrical trust" as the Login and "map" as the Password to enter the web site. Click on the "myStrength" link under My Benefits and then click to go to the myStrength sign-

up page.

Through this web site it will be possible to read articles, watch videos and try eLearning programs. The wellness portal may be accessed through the myStrength app or by calling 1-800-342-8111.

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Bundled Pricing – continued from Page 1 –

Scripps surgeons, in the panel for some of the centers. One facility, Mission Valley Heights Surgi-Center, has had a working relationship with the Plan for many years. In fact, G1 is willing to make arrangements with any surgeon to utilize one of their facilities to perform a surgical procedure pursuant to a bundled price.

Please know that it is always advisable to have any recommended surgical procedure reviewed by Best Doctors **before** it is performed to ensure that the procedure is necessary and/or that the most appropriate procedure is going to be performed. As a reminder, for completing a Best Doctors “Inter-Consultation” the calendar year deductible will be waived or reimbursed if already satisfied.

If there are any questions as to a recommended surgical procedure being necessary at all or the most appropriate procedure to address the medical issue please contact the Trust Office (x-702) or contact Best Doctors directly at 1-866-904-0910.



HEALTH INFORMATION SOURCES

Best Doctors - 1-866-904-0910 or www.bestdoctors.com; **Pinnacle** (medical and dental services in Mexico): 760-355-3943 ext 7343; Navitus (retail pharmacy and specialty medications) 1- 866-333-2757, **MedVantx** (mail order): 1-866-744-0621; **“NurseLine”**- 24/7 access to Registered Nurses at 800-250-6181 <http://healthresources.caremark.com/topic/specialty>; and for researching doctors and hospitals: www.healthgrades.com, www.leapfroggroup.org; www.Calhospitalcompare.org; www.hospitalcompare.hhs.gov; <http://www.npdb-hipdb.hrsa.gov>; **National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank** may be used to verify information on a healthcare provider; and <http://www.medbd.ca.gov/lookup.html> - **Medical Board of California for physician licensing. The California Health Care Foundation** supports <http://www.calqualitycare.org/> which combines ratings for quality of care, patient safety and patient experience in an effort to help consumers make informed choices.