

October 22, 2012

**PLEASE READ THIS NOTICE IN ITS ENTIRETY
AS IT FEATURES “\$\$\$” INCENTIVES**

TO: All Plan A PPO Participants
FROM: Board of Trustees
RE: Plan Changes/ Important Information

In the spirit of continuing to make available programs intended to assist our participants by providing extensive disease management, cost-containment opportunities and health care related support services we are pleased to report on the following new programs and/or Plan changes going into effect as of **January 1, 2013**. We urge you to pay careful attention to these programs, especially those that may provide for increased disease management guidance and/or reduced out-of-pocket expenses in return for you and/or a family member’s participation.

PLAN CHANGES:

1. Best Doctors Program Incentive

PPO participants have the ability to utilize the services of *Best Doctors* to validate a serious medical diagnosis or proposed plan of treatment for the purpose of “getting it right” at the beginning. **There is no cost to the participant to use this “confidential” service.** To find out if a diagnosis and/or a treatment plan is correct a participant should contact Best Doctors at 1-866-904-0910 so that a trained Member Advocate may **confidentially** discuss the medical issue(s), existing diagnosis, and recommended treatment plan.

If Best Doctors determines that a full review, known as an Inter-Consultation, is warranted then Best Doctors will aggregate all medical information including all physician records and tests. Following a detailed review by expert physicians, Best Doctors will deliver to the participant and their physician a summary of their findings as to whether the diagnosis and/or plan of treatment is on target. The participant is then free to use this information to make an informed decision with their physician as to how to proceed.

Starting in 2013, for each case selected by Best Doctors for full review, upon completion of the Inter-Consultation process the participant will receive a certificate of completion from Best Doctors. By remitting the certificate to the Trust Office the current year’s \$250 deductible for that participant will be waived. If any part of that year’s deductible had already been satisfied then those claims will be re-processed without a deductible for which a refund may be payable.

This incentive applies only to cases determined by Best Doctors as being a candidate for a full review. However, please do not hesitate to contact Best Doctors at 1-866-904-0910 with questions about any significant diagnosis, treatment plan and recommended surgery, especially with respect to any of the following **elective surgeries**: Low back, hysterectomy, knee and hip replacement, obesity, heart bypass graft, prostatectomy (prostate surgery), and lumpectomy/mastectomy.

2. Disease Management Program Expansion - Two new programs through Alere are:

- a. DayLink Monitor Testing - Monitors participants with more severe cases of diabetes, COPD, coronary artery disease, and heart failure. Under this program a biometric home monitoring device will be placed in the participant's home which will provide Alere with real-time, actionable information on a daily basis that will allow chronically ill participants to receive care and guidance on a regular basis outside of periodic nurse calls.

How it works: Program participants answer questions by pushing "yes" or "no" buttons. The device is able to record weight, blood glucose levels and answers to pre-programmed questions pertaining to conditions/symptoms being monitored by Alere. If necessary, a specialized nurse may be able to provide immediate guidance to the participant or notify their doctor if immediate attention is needed. Further, use of this aggregated data by the disease management nurses assists in their ongoing clinical decision making.

- b. CareAlerts - This program identifies clinical gaps in care, drug interactions and dangerous drug side effects in an effort to improve the quality of care and address medication safety by allowing a participant's health care providers to be informed of their progress, medication, adherence and potential risk issues. When necessary, messages are delivered to both the participant or their health care provider to close or prevent a gap in care **before they may escalate into a higher risk event.**

CareAlerts identifies gaps in the following areas:

1. Prevention - Preventive screening tests, immunizations, and provider follow-up visits;
2. Care Gaps - gaps in care resulting in less than optimal therapy for chronic conditions such as taking medication as prescribed or biometric monitoring goals;
3. Prescription drugs - monitoring inappropriate therapies as some drugs have higher risks; and
4. Prescription drug adherence and safety - General adherence (i.e. taking drugs as prescribed), early discontinuation of maintenance drugs, duplicate therapies, drug interactions and drug-disease interactions.

In order to be eligible to receive the benefit of these and other disease management programs, **for which there is no cost to the participant**, a participant must be enrolled through Alere. If you have a history with any of the managed chronic diseases (Asthma, diabetes, coronary artery disease, COPD and heart failure) and are **not enrolled** in the disease management program, please read the following section carefully and contact Alere at 1-800-227-3728.

3. Disease Management Program Incentive - For maintenance medication(s) applicable to one of the chronic diseases managed by Alere the prescription drug co-payment (presently 20% for generic and/or preferred brand name drugs) will be **LOWERED to the lessor of \$5 or 5%.** **However, this reduced co-payment will only be applicable at the time an eligible prescription is filled if the participant is actively enrolled in the disease management program and certified by Alere as being in full compliance with the program such as communicating with the Alere registered nurses each time contact is made. In the event a participant is contacted by Alere about being selected to receive a DayLink monitor, full compliance with the disease management program will require that the participant has consented to receive the monitor and that Alere confirms they are providing all requested information on a daily basis.**

4. Vision Service Plan Benefits

a. **The routine annual exam will be EXPANDED to include a retinal scan;**

b. The following co-pay schedule will become applicable January 1, 2013:

Annual Exam	- \$20*
Glasses	- \$20
Anti-reflective lenses	- \$20
Polycarbonate lenses	- \$20

Over recent years the retinal scan has become a fairly standard option to patients at an out-of-pocket cost ranging from \$35-\$40. The Board of Trustees has added the scan to the annual eye exam due to its effectiveness at detecting the onset of various medical conditions such as diabetes, hypertension and tumors, along with various eye conditions for which early detection and treatment can be crucial.

The co-pay for an exam and glasses has been \$10 and \$15, respectively, for over 20 years while the two lens options noted above had a \$0 co-pay. Presently, if a participant gets an exam with a retinal scan and glasses with all lens options that is fully covered under the schedule of benefits, their out-of-pocket cost would be \$60-\$65. Starting in **January 2013**, if a participant gets an exam (including a retinal scan) and that same pair of glasses, their out-of-pocket cost would be slightly higher at \$80. However, if they get only one of the two lens options or neither, their out-of-pocket cost would be closer to \$60 or \$40, respectively, which is basically equal to or less than the current out-of-pocket cost for the same services and glasses.

* In that the annual exam co-pay will become \$20 with or without a retinal scan, every effort should be made to select VSP providers who offer retinal scanning.

IMPORTANT INFORMATION

1. CVS Minute Clinics Co-payment Lowered 10/1/12 - As a reminder, under the Plan A PPO the required co-payment for a visit at any CVS Pharmacy Minute Clinic (whether in or outside of San Diego) will now be **\$10 per visit**. The balance of the charge for the Minute Clinic visit will be payable under the Plan at 100% with all other allowable charges for medical services to be payable in accordance with the Schedule of Benefits for PPO providers.

Use of Minute Clinics is for common illnesses, injuries or skin conditions such as for an eye infection, earache, cold (sore throat, cough, runny nose), nasal or sinus infection, urinary tract infection, etc., as well as to treat burns, cuts, rashes, allergies and/or bug bites/stings, or to receive preventive flu shots and vaccinations. If a prescription is issued it may be conveniently filled at that same location. In the event the Minute Clinic is unable to assist the person they will suggest a more appropriate level of medical care and there will be **no charge for the visit**. *To see what services are available or to locate a Minute Clinic please visit www.minuteclinic.com or call 866-389-2727.*

In the event more extensive treatment is required please remember that there is a \$10 office visit co-payment for all Sharp doctors and a \$30 co-payment for all other PPO doctors in San Diego County. The office visit co-payment outside of San Diego County will remain at \$15.

2. Be careful when ordering specialty drugs - Specialty medications are used in the treatment of chronic conditions and complex drug therapies such as rheumatoid arthritis (RA), multiple sclerosis (MS) and cancer. Depending on the condition and prescribed therapy, these medications may be taken orally (by mouth), intravenously (IV) or self-injected.

These medications often require special handling, such as refrigeration or time-sensitive delivery. Some of them are available only through limited distribution and many can be very expensive, in some cases costing thousands of dollars per dosage. Further, the price of specialty drugs continue to rise dramatically, especially as new drugs are introduced to the market place, and there are virtually no generic forms of such drugs.

It is important to be aware that under the PPO Plan **all** injectable medications **must** be purchased directly through the SpecialtyRx program of CVS/Caremark or a designated source in order for the full price of the medication to be considered for payment by the Plan. In the event other than a SpecialtyRx or a designated source is used by a physician to fill a specialty drug prescription the Plan will not pay more than it would have if the prescription(s) had been properly filled through SpecialtyRx or a designated source. **This means the participant would be responsible for the full balance of the cost.**

In other words, since a physician must order specialty drugs for delivery directly to the participant or to a facility at which the medication will be administered, and in the same fashion it is highly recommended to always be sure that referrals are to other PPO service providers, it is imperative that it be mentioned to a physician that Plan **requires** that they get the medication from Specialty Rx or a designated source. By not doing so the participant would be financially responsible for the balance of the cost above what the Plan would have paid if it had been obtained through Specialty Rx or a designated source.

If there is ever a question involving specialty drugs please contact your claims examiner at the Trust Office.

3. New Claim Form Process - Looking ahead to 2013, in an effort to avoid delays in processing PPO claims until a claim form is submitted for the first claim(s) of the year, a new streamlined process will be implemented that is expected to provide the Trust Office with specific information such as changes in dependent status or the existence of other group health coverage for a dependent which is integral to the claims payment process. Please be on the look-out for a special mailing this Fall that will include a new annual Registration Form that must be returned **before** any claims for services rendered in 2013 may be processed. Therefore, please complete and return them as soon as possible in the included self-addressed/stamped envelope, by fax to 858-565-2951, or via an e-mail attachment to forms@569trusts.org.

However, please note that there will still be instances where a claim form or a request for a document, information, or records may be necessary prior to processing a claim. In order to prevent any delay or a formal denial of such a claim please complete and/or provide the necessary form, document or information to the Trust Office as soon as possible.

If there are any questions about any of the above Plan changes or specific areas of information , please contact the Trust Office (x-703).

Thank you.

