December 23, 2013

TO: All Plan A PPO Participants

FROM: Board of Trustees

RE: Summary of Material Modifications/Plan Changes

Please be advised that the Plan A PPO Plan has been amended as follows:

1. Vasectomies to be covered at 100% - **Effective January 1, 2013** a vasectomy performed by a PPO provider will be covered at 100% without application of a deductible or co-insurance. Compared to the routine cost of a female sterilization of $8,000-$10,000 the cost of a vasectomy is approximately $600-$700, which is now covered in full by the Plan if performed by a PPO provider.

2. PPO Plan Co-ordination of Benefits - **Effective March 1, 2013**, where a covered employee or dependent is also a covered dependent under applicable secondary coverage the rules for co-ordinating benefits with that plan will change when the secondary coverage consists of a high deductible limit. In such event the Plan will first pay claims as the primary payer at 60% of Eligible Expenses. Following a determination as to the final amount to be paid by the secondary plan(s), any remaining balance of eligible expenses will then be paid in accordance with the Schedule of Benefits up to the total amount to have been payable if this Plan had been the Covered Employee's or Dependent's only source of group medical coverage.

   Example: A covered employee is also a covered dependent under their spouse's coverage which is a PPO plan containing a $10,000 deductible. On a hospital bill of $10,000 in eligible expenses this Plan would pay $5,850 ($10,000 - $250 deductible, then $9,750 @60%) leaving a a balance of $4,150 to be considered by the secondary plan. If the secondary plan pays $0 (due to its $10,000 deductible) this Plan would then consider the balance of eligible expenses and pay an additional $2,400 bringing the total payment up to $8,250, the amount that would have been payable if this Plan had been the sole source of group medical coverage. The participant would owe the remaining $1,750.

   However, if the hospital bill was $20,250 this Plan would have first paid $12,000 ($20,250 - $250 deductible, then $20,000 @ 60%). If the secondary plan pays $7,000 per its schedule of benefits, there would be a balance of $1,250. This Plan would then pay the remaining $1,250 leaving a $0 balance to be paid by the participant.

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3. Plan A PPO Providers in Mexico - Effective **January 1, 2014** the PPO Plan it will be possible for Plan A PPO participants to access medical service providers in various parts of Mexico who participate in a network developed by Pinnacle Claims Management, Inc. Providers are located in the following border cities: Mexicali, San Luis, Los Algodones, Tijuana and Palaco.

   To access participating providers in these areas the patient must present a special ID Card to be provided to all participants. It is very important to understand that in order for the cost of services rendered by these providers to be covered by the Plan the patient must be covered at the time services are rendered.

   Please make note that there will be NO OUT-OF POCKET COST to the participant for use of Pinnacle panel providers in Mexico. "No out-of-pocket cost" means there will be no co-payment, deductible, or co-insurance shared amount applicable to the cost of services rendered by Pinnacle panel providers so long as the services are considered to be eligible expense(s) under the Plan.

   For employees and family members working/living in Imperial County, it is our understanding that certain Pinnacle network providers will send transportation to the Mexico side of the U.S./Mexico border crossing at various times during the week to take people in need of medical attention to their facilities. Transportation will also return them to the border crossing to return to the U.S.

   Please be on the lookout for communication about this program that will include a special ID card that must be presented to a panel provider with a picture ID in order to be treated under this Program.

MAKING PLAN A AND PLAN B DIRECT PAYMENTS BY ACH TRANSFER

It is now possible to make a Direct Payments to maintain Plan A and Plan B group health insurance coverage on a computer or smart phone by accessing either the Trust's web site (www.569trusts.org) or Local Union 569 web site (www.ibew569.org). **There will be no cost to the participant for using this service.**

Direct Payments may still be made in the following ways before the stated deadline for a particular month: Mailing a check to the Trust Office, delivering a check to the Trust Office or using a debit card at the Trust Office.

When accessing this tool the participant will be able to make a payment for either the current month and/or the following month. However, in order to make a Direct Payment for the following month the participant must have satisfied their monthly cost of coverage for the current month by having had sufficient hours in their Reserve Account or remitted a Direct Payment to cover any shortfall in Reserve Account hours.

For example: Notices for Direct Payments due for January 2014 coverage will be issued in December 2013. A participant may now make a Direct Payment for December 2013 (if still necessary) and January 2014. Please note that in order to continue coverage for January 2013 the participant must have been covered for the month of December 2013.

Instructions for making an ACH Direct Payment will be included with notices advising participants that a Direct Payment may be made to continue their coverage for a particular month.

If there are any questions please contact the Trust Office (x-310).

Thank you.