CURRENTS

SAN DIEGO ELECTRICAL TRUSTS

Issue 61 November 2011

UNDER AGE 26 DEPENDENT RE-ENROLLMENT

Late last year all participants were informed as to measures taken to conform with the requirements of National Health Reform as of January 1, 2011 in accordance with all Interim Final Regulations and subsequent Technical Releases issued by the Federal Government. One of those requirements was that all children (natural child, step-child, foster child or legally adopted child) may be covered under Plan A until the date they turn age 26. Previously they would have only been eligible to continue as a covered dependent between ages 19 – 25 if they were still dependent upon the Covered Employee and enrolled as a full-time student in a recognized educational institution. Full-time student status and dependency requirements are no longer required to be enrolled as a Dependent Child in the Plan.

At that time it was announced that qualifying dependent children under age 26 who were **previously covered** under either Plan A PPO or Kaiser must be re-enrolled **prior to January 1, 2011.** It was noted that this would be a one-time opportunity to re-enroll all formerly covered dependent children who may now qualify under federal law and that failure to return a new enrollment card listing all newly enrolled dependents by January 1, 2011 would mean that it would not be possible to re-enroll them.

Please be advised that there will be one final opportunity to re-enroll dependents currently under age 26 who would have qualified for reinstatement as of January 1, 2011 in accordance with the federal guidelines. However, it is important to understand that coverage for all newly re-enrolled dependents will be subject to all of the following terms and conditions:

1. A new enrollment card must be properly completed and contain required information about all persons to be covered as a dependent;
2. All required support documentation (birth certificates, court papers, etc.) must be remitted to the Trust Office prior to coverage being verified and/or claims paid on behalf of any newly enrolled Dependent Child;
3. The enrollment card **must be received** at the Trust Office by no later than Tuesday, January 3, 2012. This means the enrollment card must be delivered in person or, if mailed, there must be a postmark on the envelope of no later than December 31, 2011; and
4. Coverage for all timely enrolled dependent children will become effective January 1, 2012 and will be subject to all Plan provisions applicable to newly eligible dependents.

This special re-enrollment process will be the absolute final opportunity to reinstate coverage for formerly covered dependent children under age 26. For all such re-enrolled dependents it is very important to understand that their effective date will NOT be retroactive to January 1, 2011, meaning there will be no coverage under the Plan during calendar year 2011.

Should there be any questions relative to the above or the re-enrollment process please contact the Trust Office (858-569-6322 x 310).

"GETTING IT RIGHT" BEST DOCTORS PROGRAM

Recognizing the importance of making sure that any and all serious diagnoses, recommended surgeries or medications are correct before undergoing surgery, starting a plan of treatment or an extensive medication regimen, Plan A PPO participants may seek independent confirmation of a diagnosis and/or treatment plan through "Best Doctors" which will perform a confidential Best Doctors Check-up at **no cost to you**.

A Best Doctors historical study shows that 22% of their cases have a change in diagnosis, 61% of cases have a change in treatment and 38% of cases have unnecessary surgery recommendations. The main reasons people contact Best Doctors are: No diagnosis, not understanding a diagnosis, symptoms not improving, questions as to the need for recommended surgery, or a need for

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BEST DOCTORS PROGRAM

help in deciding between multiple proposed treatment options.

By calling Best Doctors (1-866-904-0910) a Member Advocate will listen to and answer all questions as to a diagnosis and a proposed treatment plan. The Member Advocate will take the participant's complete medical history and if further review is warranted Best Doctors will aggregate all medical information including all physician records and tests. Following a very extensive and 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. If necessary, Best Doctors will match participants with an expert PPO physician.

There have been questions as to whether using Best Doctors will require replacing your relationship with your current physician(s). The answer is "no" as this program is intended to offer additional resources, education and support to both the participant and their treating physician. Statistics show that well over 90% of the time the participant's treating physician works in tandem with Best Doctors in the patient's best interests to focus on "getting it right".

In any situation where you may be dealing with a significant medical condition, recommended surgery or extensive treatment plan we urge you to find out more about the Best Doctors program or services by calling 1-866-904-0910, going to www.bestdoctors.com or to send your diagnosis or treatment plan through to Best Doctors you should email info@bestdoctors.com.

Please keep in mind that a participant must be eligible for Plan A PPO coverage at the time the Best Doctors service is sought as well as when any resulting medical services are rendered in order for such services or group medical coverage to be applicable.

Should there be any questions as to when and how to use the Best Doctors program please contact the Trust Office.(858-569-6322 x 710).

PPO HEALTH MANAGEMENT PROGRAM

Did you know that the PPO Plan offers a free program to help keep you and your family healthy? For those not familiar with the Alere Health Management Program, it is a phone-based program that provides additional education and support for those with chronic conditions such as Asthma, Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Heart Failure. The program launched in August of 2007 has helped to improve the overall health and wellness of hundreds of plan participants while also having reduced claim costs associated with the above chronic conditions by almost $1 million dollars. These savings were achieved through effective management of chronic conditions and the reduction of unnecessary and extremely expensive emergency room visits and/or hospital admits. Please remember to think of using a PPO urgent care facility in instances where there is no apparent emergent need for medical care. Sharp Rees Stealy is a PPO provider that has many such facilities throughout San Diego County.

The Board of Trustees believe that good health is most important, which is why this program is so highly recommended. Currently there are over 330 individuals participating, but the goal is to achieve 100% participation for those people managing at least one significant chronic condition so that everyone will be on a path to improved health as well as working to prevent the onset of additional chronic conditions. Therefore, Alere will be conducting a re-contact campaign in January 2012 to reach out to those individuals who previously did not respond to phone calls or enroll in the Alere Health Management Program.

To everyone in the PPO Plan who has a chronic condition and is not participating in the Health Management Program, you can expect to receive a letter and phone calls from Alere in January 2012. Of course, if you prefer not to wait for Alere to contact you, please contact Alere and enroll in the Health Management Program by calling 1-800-227-3728. Again, there is **no cost** for this program other than investing a little bit of time by making or taking a phone call and working with an Alere registered nurse who is well versed in the management of chronic conditions. Information is power and what better return on an investment can there be than improving one's overall health?

REVISED PLAN A PPO IDENTIFICATION CARDS

Following the recent distribution of revised ID cards to PPO participants, which were prepared in accordance with national Anthem Blue Cross requirements and guidelines, the Trust Office received numerous calls asking if the routine physical exam benefit had been discontinued since the contact phone number was not included. Please note that there was no such change to the routine physical exam benefits as they are outlined in the Summary Plan Description booklet.

Right around the same time, Anthem advised that as of January 1, 2012 it will become necessary to add to the ID card another phone number for "Provider Only Medical Claims Inquiries". Therefore, a new ID card has been prepared and recently distributed that reflects both the telephone number for contacting Sharp Rees-Stealy to schedule a "free" physical exam and the new entry required by Anthem.

Upon receipt of the new ID cards please dispose of the prior card(s) and immediately commence using the replacements. Should there be a need for additional ID cards please contact the Trust Office (858-569-6322 x 310).

IMPORTANT COVERAGE RELATED REMINDERS

Waiver of Spouse/Domestic Partner Group Medical Benefits.

It is important for all Covered Spouses or Domestic Partners to remember that following any open-enrollment period for employer sponsored group medical coverage occurring in August 2011 or later, as of the effective date of their group medical coverage election if they voluntarily declined or waived group medical coverage available to them through their employment or some other source of group coverage free of charge, or if they receive any form of compensation in return for waiving or declining said coverage, the Covered Spouse or Domestic Partner would have no medical coverage under Plan A. However, they will be eligible for Plan A dental and vision benefits.

For example, if the employer of a Covered Dependent Spouse or Domestic Partner conducts their next open-enrollment in November 2011, to be applicable to coverage effective January 1, 2012, and the Dependent Spouse or Domestic Partner declines or waives such medical coverage that would have been available to them free of cost, or for which they receive any form of compensation as a result of having done so, their group medical coverage under the San Diego Electrical Health & Welfare Plan will terminate as of January 1, 2012. If there is a later open-enrollment period then this exclusion will become effective with the date their free medical coverage and/or compensation would otherwise go into effect.

Should there be any questions please contact the Trust Office (858-569-6322 x 310).

Beware of Advertised Medical Treatment Programs.

Despite repeated warnings as to businesses advertising medical treatment programs, in particular those for rapid weight-loss, involving extensive surgical procedures that are proclaimed to be **covered by PPO health insurance** there are still many participants who seek these treatments only to find out after it is too late that many of the pre and/or post surgical tests and/or services administered by these service providers are not actually covered by their group insurance.

As was explained, most group health plans, such as the Plan A PPO Plan, follow very specific preauthorization guidelines to determine when such surgical procedures will be covered and under what circumstances. In particular, a surgical procedure may be pre-authorized, but the provider then has the patient undergo a substantial number of "pre-surgery" diagnostic tests and/or procedures that may not be medically necessary or considered part of the approved surgical procedure, thus they would not be covered even though the surgery has been approved.

This places the participant in a difficult position when it is learned after both the procedure has been performed and the claims are filed with the Plan that the charges have been either denied (due to the absence of pre-authorization) or substantially reduced if the authorized services were performed by providers and facilities which are not Blue Cross PPO providers.

The following are examples as to how expensive making this mistake with some of these weight-loss programs may be:

1. Total billed charges for a weight-loss surgical procedure exceeded $100,000 which included $40,000 in hospital and anesthesiologist charges for services rendered by PPO providers. The remaining charges included a surgeon's fee ($34,300), assistant surgeon's fee ($11,900), and **a tremendous amount of diagnostic and laboratory work performed prior to and following the procedure that were rendered by non-PPO service providers.** If payable under the Plan, all of the non-PPO provider charges will be paid at 60% of what the PPO maximum discounted allowance would have been and the participant would owe the balance of billed charges.
2. A 2-day hospital confinement at a PPO hospital for a weight-loss procedure was billed at $78,000 and the surgeon separately billed $14,500. If this procedure hadn't been approved in advance there would be no coverage and the participant could be responsible for all billed charges.

IMPORTANT - There are many advertisements for such medical programs, especially ones suggesting they are "Covered by PPO Insurance". Before committing to any advertised program for weight-loss or the treatment of any medical condition please contact your claims examiner to be sure what is being proposed is covered by the Plan. Remember, there is a significant difference in your out-of-pocket liability if non-PPO providers are used as noted in example 1 above. In other words, using only PPO providers is very important to protect against unexpected out of pocket exposure, but the Plan can only pay for eligible medical expenses which sometimes requires advance authorization to be received. **Therefore, after approval of a surgical procedure for an advertised program please pay careful attention to any services to be rendered before or after the procedure. It is highly recommended that participants contact the Trust Office before any pre or post surgery services are rendered in order to prevent falling prey to the above.**

Dependent Eligibility Verification Audits.

In an effort to ensure that only eligible dependents are enrolled the process of verifying eligibility status of all dependents is underway as the first two rounds of letters sent to participants have been issued by Eligibility Verification, Inc, an independent contractor expert in the dependent audit and verification process.

This process is being performed because the U.S. Department of Labor has reported that 5% - 15% of dependents who are self-reported by employees to group health plans are actually ineligible. The resulting cost to a group health plan per ineligible dependent has been estimated at $2,000 - $5,000. According to these statistics, if there were 150 enrolled dependents that are truly not eligibles to be covered, the cost to the Plan, and ultimately the Covered Employees, would be between $300,000 and $750,000 annually or approximately $0.10/hr - $ 0.25/hr in contributions.

The expected completion of this process will be in December 2011 with the Trust Office to be advised as to which dependent(s) of Covered Employees are truly eligible for coverage and services through the Plan. It is important to understand that failure to respond to this verification request could result in the Trust Office being unable to verify that a dependent may be covered upon request from a service provider or for claims to be paid until such time as the dependent(s) are verified as being eligible under the Plan.

Therefore, upon receiving correspondence from EVI, please cooperate by responding on a timely basis.

SAN DIEGO ELECTRICAL INDUSTRY TRUSTS

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HEALTH INFORMATION SOURCES

Best Doctors - 1-866-904-0910 or www.bestdoctors.com; Caremark - www.Caremark.com; Specialty medications - CVS/Caremark at 1-800-237-2767; "NurseLine"-24/7 access to Registered Nurses at 800-250-6181 or 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.npdbhipdb.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 www.CalHospitalCompare.org which combines ratings for quality of care, patient safety and patient experience in an effort to help consumers make informed choices.

H&W/PENSION TRUST OFFICE HOLIDAY SCHEDULE
The Trust Office will be closed on Friday, 12/23/11, Monday, 12/26/11 and Monday, 1/2/12

Happy Holidays and New Year!

NEW KAISER DIS-ENROLLMENT RULES

In accordance with new guidelines issued by the Centers for Medicare and Medicaid Services the Trust Office was recently informed by Kaiser that in the event a participant voluntarily elects to discontinue their Kaiser coverage they must make such a determination known no less than 21 days prior to the first day of the next month in order for their termination of coverage to be effective the first day of the next calendar month. In the event notification is received less than 21 days prior to the end of a month the effective date of the participant's termination will be the first day of the next following month. The importance of being aware of this new rule is that it will no longer be possible to terminate Kaiser coverage effective the same month in which notification is received by the Trust Office, nor will it be possible to terminate coverage retroactively with the Trust being able to recoup previously paid premium. Therefore, since coverage for the current month may no longer be terminated, any Direct Payments or Plan C deductions paid for the current month's coverage may no longer be returned. Further, if notice is provided less than 21 days prior to the first day of the next month then a Direct Payment or Plan C deduction for the following month will still be required.