CURRENTS

SAN DIEGO ELECTRICAL TRUSTS

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PLAN A PPO PROVIDERS IN MEXICO - SPECIAL ID CARD REQUIRED

Since **January 1, 2014** covered Plan A PPO participants are able 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.

SPECIAL ID CARD: Recently all Plan A PPO participants were sent a Pinnacle ID card that is required to access any of their panel providers in Mexico. This special ID card must be presented to a Pinnacle panel provider with a picture ID in order to be treated under this Program.

THIS CARD DOES NOT REPLACE THE ANTHEM BLUE CROSS ID CARD TO BE USED FOR ALL SERVICE PROVIDERS OTHER THAN PINNACLE NETWORK PROVIDERS IN MEXICO.

In order for the cost of eligible services rendered by PPO providers in Mexico to be covered by the Plan the **patient must be covered at the time services are rendered**. For eligible dependents to be able to access participating providers in Mexico they must be fully enrolled through the Trust Office. This means that the Covered Employee has filed a completed Enrollment Card and all necessary documentation for listed dependents with the Trust Office. Failure to complete this process may prevent accessing care from any medical providers in Mexico or the U.S. because it will not be possible for the Trust Office to verify that the person to be treated is covered until all necessary enrollment information or documentation is provided.

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.

To get information as to participating PPO providers in Mexico please contact Pinnacle at 1- 800-649-9121 or www.pinnacletpa.com. Please understand that the Trust Office does not recommend specific providers.

NEW SHARP REES-STEALY FACILITY IN DEL MAR

A new Sharp Rees-Stealy facility has just opened at 2600 Via De La Valle, Suite 200, Del Mar, CA 92014. Services available at this facility are: Dermatology, Diabetes Education, Endocrinology, Family Medicine, Internal Medicine, Laboratory Scheduling, OBGYN, Orthopedics, and Radiology. Free parking and evening appointments are available.

Information on all Sharp facilities and providers is available at 1-800-827-4277 or www.sharp.com.

FILE YOUR 2014 BLUE CLAIMS UPDATE FORM

In an effort to expedite the processing of claims at the beginning of each calendar year a blue information update form is sent to all Plan A PPO Covered Employees requesting basic information that the Trust Office must have in order to process the first claim(s) submitted on themselves or covered dependents. In the absence of this updated information being on file a delay will occur because it will be necessary for the Trust Office to send out a claim form asking for the same information.

Please note that if a claim is received that suggests the services were related to an accident, in particular automobile or work related incidents, even if the blue form had already been submitted for the current calendar year it will still be necessary for the Trust Office to request completion of a claim form so that a detailed explanation as to the date, time, location and nature of the

Continued on inside–

WHAT'S INSIDE

FILE YOUR 2014 BLUE CLAIMS UPDATE – Continued from cover—

accident may be determined since this will determine the level of benefits payable by the Plan.

If you have not returned this form for 2014 please do so as soon as possible. In general, it is important to respond to any and all requests for information from the Trust Office in order to prevent avoidable delays in verifying coverage or processing claim payments.

MAKING DIRECT PAYMENTS BY ACH TRANSFER

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

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

A reminder as to 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).

FREE ROUTINE PHYSICAL EXAMS

Are you over the age of 50? Then did you know you should get a colonoscopy every 10 years and regular blood work?

Are you a female over the age of 40? Then did you know that you should get a mammogram every 1-2 years and regular blood work?

Are you over the age of 21? Then did you know that you should be getting your cholesterol checked?

Under the Plan A PPO Plan, for all covered employees and their spouse, if applicable, it may be possible to undergo a **FREE** routine physical exam that includes the above testing if scheduled and performed through Sharp Rees-Stealy's Occupational Medicine Department. The frequency of permitted exams is based upon age.

Please note that under the PPO Plan it may also be possible to undergo a periodic routine physical exam with any other PPO doctor, including Sharp Rees-Stealy, BUT there would be a substantial out-of-pocket cost to do so versus **FREE** through Sharp Rees-Stealy's Occupational Medicine Department. To inquire about scheduling a FREE routine physical examination through Sharp Rees- Stealy Occupational Medicine contact Carmen Quinn at (858) 616-8411.

DO NOT PRE-PAY SHARP REES-STEALY FEES

When using Sharp Rees-Stealy providers, at or before the time of service you may be requested to pay $90 for an office visit or a specified amount for other services or testing. This request is being made as a result of many of the insurance programs they participate in carrying high deductibles resulting in participants ultimately being responsible for payment of most or all eligible expenses up to that high deductible limit.

Under the PPO Plan, for any Sharp Rees-Stealy provider office visit it is only necessary to pay a $10 co-payment as the full balance of the office visit charge will be paid by the Plan at 100%. For any other services to be rendered during a Sharp Rees-Stealy provider office visit, or at another time, you should **NOT** make any requested payment until after receiving the Explanation of Benefits Form from the Trust Office outlining the appropriate discount amount(s) and how much, if any, of the allowed charge(s) is your responsibility. If you pay what is being requested it is possible the amount is too high and may result in an overpayment by the participant.

Upon refusing to make any further payment at that time, the individual making the payment request is supposed to permit the scheduled visit or services to be rendered. If they refuse to do so, you should request to speak with someone in management and let them know that our participants are not to be subject to any pre-payment requirement other than an office visit co-payment. If that doesn't work, please take down their name(s) and inform the Trust Office immediately as the episode will be reported directly to their Chief Executive Officer of Sharp Rees-Stealy.

IMPERIAL VALLEY TRAINING CENTER UPDATE

BY TAMMY SPINKS

It has been a busy time of expansion and opportunity in the Valley. Serving the needs of our growing membership has proven to be a rewarding challenge. We strive to accommodate the increase in our Apprenticeship class sizes by continually improving and developing new labs and training devices to insure that the students receive the same quality of Apprenticeship our San Diego students are accustomed to. One focus has been to incorporate a variety of labs replicating experiences in commercial facilities to help form and expand our students knowledge base with general electrical skills. With the potential of geothermal plants on the rise, we are also planning to introduce more industrial lab applications to prepare for the upcoming demand.

The large numbers of workers required to construct renewable energy jobs of this magnitude have enabled us to put hundreds of local residences to work providing them with the beginning foundations of a career. Many of our new members have received the classification of Construction Wireman. They are required by the State of California to attend training sessions for advancement in their respective classification and we have met that demand. We currently held over forty-five classes for these students. Our classes help to prepare them for entry level electrical positions making them a more valuable resource to their employers and communities. These courses offer them a unique opportunity and introduction into the electrical field while they prepare themselves to meet the requirements of our Apprenticeship program. We have had several students enter the Apprenticeship after becoming a Construction Wireman.

There has been growing interest in a greater variety and frequency of Journeyman classes held in Imperial Valley. We have added several courses to our continuing education offerings. We added an OSHA 30/EM385, a State Certification Preparation class, and an NFPA 70E Arc Flash to name a few. Make sure to review the Spring Journeymen Class Schedule to take advantage of these courses and fulfill your Certification renewal requirement.

Part of what we do is educating the community about who we are and what we provide. We utilize outreach events to inform the public and local government of how important quality workforce training and our Apprenticeship program are to the future of jobs in Imperial County. If you are in the area, please stop by for a tour of our facility and see the difference.

PLAN A PPO PLAN AMENDMENTS

PLEASE REVIEW THESE SIGNIFICANT CHANGES CAREFULLY!

1. Certain Elective Surgeries with NO OUT-OF-POCKET COST!

It has been reported by the Best Doctors program that in their vast experience of reviewing medical cases, 38% of recommended surgeries are totally unnecessary and another 18% of recommended procedures would not be the best one for the patient. Further, Best Doctors statistics identify a series of elective (non-emergency) procedures that routinely fall into these categories.

In particular, attention should be paid to ensuring that the following elective surgeries are truly necessary and will afford a patient the greatest opportunity for a favorable outcome: **back, hysterectomy, knee and hip replacement, obesity or bariatric, coronary artery by-pass graft, heart valve replacements, prostatectomy and lumpectomy/mastectomy.**

Effective immediately, for services performed by, and at a PPO Provider, all Eligible Expense pertaining to the performance of any of these listed elective surgical procedures will be paid at 100% if a Best Doctors "Inter-Consultation" is completed before the procedure is performed.

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 for Eligible Expenses to be covered by the Plan subject to application of any other limitations. In the event Best Doctors determines that an "Inter-Consultation" is not necessary, this provision 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 Plan A at the time in order to qualify to receive the Best Doctors services offered by the Plan at no cost to the participant.

2. Affordable Care Act Requirements - The following changes became effective January 1,2014:

A. The annual maximum of $2,000,000 was replaced with "Unlimited";

B. Under the Schedule of Benefits the maximum out-of-pocket cost per Covered Person per calendar year is $1,750 (deductible of $250 and $1,500, i.e. 20% of the first $7,500). There is a maximum of two full deductibles, or a combined family total of deductibles of $750, in any calendar year and there may also be out-of-pocket costs for office visit and prescription drug co-payments payable throughout the year.

In addition, there is a provision under the new federal law that provides for an out-ofpocket maximum per calendar year of $6,350 for a single person and $12,700 for all Covered Persons in the same family. The term "out-of-pocket" expenses includes deductibles, coinsurance, and co-payments including drugs, office visits, and all other expenses covered under the Plan. However, not included in the out-ofpocket maximum are Direct Payment amounts, amounts paid for services rendered by out-of-network providers or expenses for non-covered services.

C. There shall no longer be application of a Pre-existing Condition exclusion; and

D. Routine patient costs incurred by a qualified Covered Person when participating in only approved clinical trials relating to cancer or other life-threatening disease or conditions will now be covered by the Plan. Routine patient costs include only those related to the clinical trial which would normally be paid for a Covered Person who is not in a clinical trial. However, excluded from routine patient costs are expenses of the investigational item, device or service as well as expenses related to data collection and analysis needs or services that are clearly inconsistent with widely accepted standards of care for a particular diagnosis.

Pursuant to the Affordable Care Act of 2010 and the Public Health Service Act, effective January 1, 2014, Routine Patient Cost incurred by a Qualified Individual for items or services furnished in connection with participation in an Approved Clinical Trial are eligible under this Plan. Routine Patient Cost will not be subject to the Experimental and/or Investigational analysis or exclusion under this Plan. Routine Patient Costs are subject to all other terms and conditions of this Plan.

For purposes of this provision the following definitions are applicable:

Routine Patient Cost are those costs of items and services consistent with the coverage provided under the Plan for a Qualified Individual who is not enrolled in a clinical trial.

The following associated costs are excluded from the definition of Routine Patient Cost:

1. The cost of the investigational item, device or service;
2. The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; or
3. The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. A Qualified Individual is a Person who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to treatment of cancer or another life-threatening disease or condition. A determination that the Qualified Individual's participation in the Approved Clinical Trial is appropriate to treat the disease or condition must be evidenced by either documentation from the referring health care professional or based on the provision of medical and scientific information from the Administrator or individual.

Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition and is one of the following

1. A federally funded or approved trial;
2. A clinical trial conducted under an FDA investigational new drug application; or
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Please contact your claims examiner at the Trust Office with any questions.

RE-ALIGNMENT OF PPO CLAIMS EXAMINERS

Due to the substantial growth in the size of Plan A PPO participants over the last year an additional claims examiner has been added to the Trust Office staff. Effective immediately the assignment by last name will be as follows: Jenny (x306) A-F; Adrienne (x307) G-K; Tina (x309) L-R; and Audrey (x308) S-Z.

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PENSION PLAN AMENDMENT RECIPROCAL TRANSFERS

The Pension Plan has been amended to reaffirm the process of transferring and receiving reciprocal contributions.

A transfer of contributions to or from this Fund is made pursuant to the terms of the Electrical Industry Pension Reciprocal Agreement. It is the sole responsibility of the individual employee requesting a transfer of contributions to timely register for transfers and to file any and all required forms with the appropriate Fund.

An employee's Home Fund is the Pension Fund of the IBEW Local Union to which they are a member. If an employee is not a member of an IBEW Local Union or their IBEW Local Union does not have a pension fund, or they are not a Participant in or has no credited service in their Local Union's Fund, then their Home Fund will be the participating Fund or Funds in which they are currently a Participant or have credited service at the time they file an authorization form requesting reciprocity.

Contributions must be transferred at least monthly. However, this Fund shall not forward any decoupled contributions to any participating Fund (s) and incoming reciprocal contributions received by this Fund from a participating Fund shall be subject to a proportionate decoupling on the same basis as if the contributions were remitted by a signatory employer.

If there are any questions relative to reciprocity please contact the Trust Office at 858-569-6322 or 800-632-2569 (x-310).

DRUG TESTING WELLNESS BENEFIT CHANGE

Please be advised that for all authorized drug tests administered under the NECA/IBEW Drug- Free Workforce Program on or after March 1, 2014 (i.e. birthday, random, post-accident, return-to-work) the amount of the wellness benefit payable for a negative test to any participant who was eligible for Plan A or Plan B coverage at the time of the test will be lowered from $60 to $50. This change is being made to prevent future increases to the hourly contribution rate.

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.