



CURRENTS

SAN DIEGO ELECTRICAL TRUSTS

Issue 58

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PPO PLAN AMENDMENTS

1. Student Accident Insurance - Effective **May 1, 2011** the Plan has been amended to define the term "Student Accident Insurance" as any individual or group insurance policy covering a Dependent Child for an accident, injury or an event requiring immediate and/or future medical services.

In particular, with respect to a Dependent Child's participation in sporting events this term 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 participating in an All-Star or traveling sports team that may not be representative of, or sponsored by, an educational institution.

Under the Plan, as amended, if a Dependent Child is injured while participating in a sporting event for which Student Accident Insurance is applicable it will be necessary to file a claim for medical coverage with the Student Accident Insurance policy before the Plan will be in a position to determine what additional benefits may be payable.

It is important to understand that this provision is applicable only if a Student Accident insurance policy is in effect at the time of the incident and when related or resulting medical services are rendered. However, if such a 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 said policy have been paid.

2. Coordination of Benefits - In theory, national Co-ordination of Benefits rules are intended to provide that 100% of eligible expenses are covered between multiple group policies. Unfortunately, the extreme differences in the nature of group coverages sometimes makes this impossible, such as when there exists an HMO or managed care plan where there are no benefits payable for the services rendered.

Effective immediately, the Plan has been amended to provide that in instances where there exists other group insurance, the Plan, if primary payor, will pay all Eligible Expenses exceeding the deductible at 60%. However, if the secondary payor is an HMO/Managed Care Program for which there would be no benefits payable for the services rendered the Plan will make payment on the balance of Eligible Expenses in accordance with the Schedule of Benefits as if there were no secondary coverage.

Examples:

- a. Where there are two group plans involved with this Plan as primary and the secondary plan is not an HMO or managed care plan:

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ADVERTISED MEDICAL TREATMENT PROGRAMS

Hardly a day may go by without hearing or reading about businesses offering medical treatment programs, in particular for rapid weight-loss, which involve extensive surgical procedures that are being proclaimed to be covered by health insurance.

The problem is that this is not always true and many group health plans, such as the Plan A PPO Plan, have specific pre-authorization guidelines for when such surgical procedures will be covered and under what circumstances. A more significant problem will occur if it is learned after both the procedure has been performed and claims have been filed with the Plan that the charges have been either denied (due to the absence of pre-authorization) or substantially reduced if the program's

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If a claim is filed totaling \$7,750, this Plan would pay \$4,500 (60% of \$7,500 after the \$250 deductible) and the secondary plan would expectedly owe the remaining \$3,250. In this case the participant would therefore owe \$0.

- b. If the second plan is an HMO or managed care plan: For the same claim totaling \$7,750, this Plan will now pay \$6,000 (80% of \$7,500 after the \$250 deductible) and the participant would owe \$1,750.

For a larger claim totaling \$20,250, this Plan will now pay \$18,500 (80% of the first \$7,500 after the \$250 deductible and 100% of the remaining \$12,000) and the participant would owe \$1,750 (the out-of-pocket max.).

It should be noted that when a Covered Person (employee or dependent) has access to a second group medical plan which is an HMO or managed care plan, by using that other plan to receive medical services, not only will there be nothing more owed for the services rendered but this Plan will reimburse you for any out of pocket co-payments.

In other words, when an available secondary HMO or managed care plan is used there are:

- 1. Advantages to the participant there is ultimately nothing owed to cover all services rendered other than any scheduled co-payments (office visits, prescription drugs). However, the participant would end up with \$0 out of pocket costs as this Plan would reimburse them for any co-payments.*
- 2. Advantages to the Trust the only payments to be made would be to reimburse the participant for their co-payments.*

Should there be any questions relative to the above please do not hesitate to contact your claims examiner at the Trust Office (x-310).

providers and facilities are not Blue Cross PPO providers.

Recent examples as to how expensive some of these weight-loss programs may be are:

1. Total billed charges 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. 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 was billed at \$78,000 and the surgeon billed \$14,500. If this procedure hadn't been approved in advance there could be no coverage and the participant could be responsible for all billed charges.

ADVICE - Before committing to any advertised program for weight-loss or the treatment of any medical condition please contact the Trust Office to be sure what is being proposed is covered by the Plan and to be reminded that there will be a significant difference in your out-of-pocket liability if non-PPO providers are used as noted in the example 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 performed.

Please be aware that all Plan A Participants will be receiving new Identification Cards within the next month or two that will replace the current ID card which is the six-sided white paper card with blue ink. This is different from the hard plastic Prescription Drug ID card all Plan A PPO participants should have in their possession. That said, this new card being provided through Blue Cross will include our group's CVS Caremark identification information.

The reason our ID cards are being changed is that there will be a slight modification to the current claims adjudication process as follows:

1. The new card will direct service providers to file their claims directly with Blue Cross (electronically if possible) instead of directly to the Trust Office; and
2. Checks to service providers will start to be issued by Blue Cross. However, the claim will still be processed in the Trust Office and the Explanation of Benefit forms will continue to be sent to participants to advise as to what charges were received and how they were paid will still come from the Trust Office.

This transition has multiple advantages to the Trust, Trustees and participants as there are additional discounts applicable to hospital charges, which will save both the participants and Trust a substantial amount of money. This will help to reduce current year claim costs and resulting future year funding costs. Further, by Blue Cross being able to aggregate the Plan's claims data within their data base they will be able to provide the Trustees and professionals with valuable in-depth claims data and statistics that will allow for greater insight into what factors are driving utilization and claim costs.

There will be a notice sent with the new ID Cards advising as to when this new process will go into effect.

BECOME A CALCTP CERTIFIED ELECTRICIAN

California Advanced Lighting Controls Training Program Offered at the Training Center

The California Advanced Lighting Controls Training Program (CALCTP) course offered at the San Diego Electrical Training Center is a statewide initiative aimed at increasing the use of lighting controls in commercial buildings and industrial facilities.

Through proper installation, advanced lighting controls improve energy efficiency in commercial facilities and save significant dollars. CALCTP will educate, train and certify licensed electrical contractors, and state certified general electricians in the proper design, installation and commissioning of advanced lighting control systems.

CALCTP trains licensed C-10 electrical contractors and state certified general electricians in effective techniques to install, tune, commission and maintain advanced lighting control systems.

Why get Certified? CALCTP will dramatically increase the demand for lighting controls in commercial buildings. For a building to be eligible for incentives, CALCTP partner utilities, which encompass over 90% of the California market, will require CALCTP-certified contractors and general electricians on each project. If you want to be part of this growing work opportunity, you must be certified.

To meet this demand, the Training Center has invested over \$200,000 in equipment.

What Are the Prerequisites? Because the lecture and lab work moves along at a challenging pace, all participants must be equally prepared prior to enrollment. The prerequisite studies are on the Lighting Controls Association website—modules EE101, EE102, EE103, and EE201 (Approximately 15 hours). These courses can be found at http://aboutlightingcontrols.org/Education_Express/welcome.php. For enrollment in CALCTP, applicants must present the certificates of completion for online study to the Training Center prior to enrollment in the CALCTP course.

What is Covered in the Course? This course has seventeen (17) sessions and is divided into seven modules consisting of both lecture and lab activities. The module content is organized to answer the following questions about lighting controls: what they are, what they do, where they are used, and how they are installed. Each "lecture" contains one or more interactive components, including group discussions, device demonstrations and/ or calculation exercises. The corresponding lab period, following the lecture, allows the attendee to directly apply what has been learned by installing the devices on specially-designed lab boards, under the supervision of the CALCTP-certified instructor(s). Take the free online courses and become a CALCTP Certified Electrician!

REVISED HEALTH & WELFARE TRUST ENROLLMENT CARDS

As announced in late 2010, a complete re-enrollment will be conducted for the purpose of having new Health & Welfare Trust enrollment cards completed by all participants to ensure that all enrolled dependents meet the definition of an "Eligible Dependent".

Due to the importance of this exercise to the proper administration of the Plan a new enrollment card is required from 100% of all Covered Employees. Thus, a second mailing of enrollment cards has now been sent to those who did not respond to the initial mailing. In the interim, it is important to be aware that the absence of an updated enrollment card will result in the Trust Office being unable to verify medical, prescription drug, dental, vision or MAP coverage on behalf of a Dependent. If you have not completed and remitted a new enrollment card set (including a new Pension Trust Enrollment Card) to the Trust Office in the last 3 months we urge you to contact the Trust Office immediately and complete this process in order to avoid any delay with respect to coverage verification or resulting claim payments.

If you are now completing a new Health & Welfare enrollment card it is important to understand that the one-time 30-day opportunity to enroll previously covered dependent children under age 26 who were not a covered dependent as a full-time student during the Fall and early Winter of 2010 expired as of December 31, 2010. In other words, only dependent children under age 26 who were covered as of the end of December 2010 may be listed at this time on a new enrollment card as a covered dependent.

DEPENDENT ELIGIBILITY VERIFICATION AUDIT

As a reminder, during the late Spring and Summer an independent third party will conduct a verification of dependents audit to ensure that only truly eligible dependents are covered by the Plan. Should there be any questions relative to the revised Enrollment and Record Cards please contact the Trust Office (x-310).

CALCTP (CALIFORNIA ADVANCED LIGHTING CONTROL TRAINING PROGRAM)

PRE-REQUISITE:

- Must be a State Certified General Electrician
- Completion of all lighting control courses offered by the Lighting Control Association (LCA) **is required prior to enrollment.** These lighting control courses can be found at http://aboutlightingcontrols.org/Education_Express/welcome.php.
- Print and submit CALCTP online certificates, totaling 150 CALCTP points, and bring certificates to the Training Center in order to be enrolled in the class.

Day(s)	Dates	# of Sessions	Time	Location	Instructors
MT	5/23-7/25	17	5-8p	San Diego	Hemingway/Stark/Tabbert
MW	5/23-7/25	17	5-8p	San Diego	Hemingway/Stark/Tabbert
MTh	5/23-7/25	17	5-8p	San Diego	Hemingway/Stark/Tabbert

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ALERE CONDITION MANAGEMENT SERVICES

There's been an important change to the Condition Management Services currently provided through Alere (formerly known as the Disease Management Program). Since January 31, 2011, the new program telephone number to call is **(866) 201-4601**.

Participants in the Condition Management Services program may receive a call from their Alere nurse if they are eligible for any new program enhancements. If you have any questions, comments, complaints or concerns, please call the new program number Monday through Thursday from 9 a.m. to 7 p.m., or Friday and Saturday from 9 a.m. to 6 p.m.

Please note that Alere's services are educational in nature and are not intended to constitute healthcare. If you have any concerns about your health, you should contact your physician, or in an emergency, call 911. If there is a question as to whether urgent care is necessary please contact the 24-hour nurse line at **800-250-6181**.

Alere can accommodate special communications needs when trying to contact them. For relay assistance services, please call (800) 877-8973 (Voice/TTY/ASCII) or (800) 855-4000 (Sprint TTY Operator Services).

HEALTH INFORMATION SOURCES

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 or www.hospitalcompare.hhs.gov;

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;

<http://www.npdb-hipdb.hrsa.gov/> - National Practitioner Data Bank/ Health care Integrity and Protection Data Bank may be used to verify information on a health care provider;
and

<http://www.medbd.ca.gov/lookup.html> - Medical Board of California for physician licensing.