



CURRENTS

SAN DIEGO ELECTRICAL TRUSTS

Issue 80

December 2015

CHANGE IN PPO PLAN PHARMACY BENEFIT MANAGER AS OF 1/1/16

Prescription drug costs are expected to increase by 10% in 2016, largely fueled by the extraordinarily high cost of specialty drugs (injectable and infused), in particular newly approved medications by the FDA. To the PPO Plan's \$2.5 million drug spend such an increase will cost about \$250,000 or about 6¢/hr.

In an effort to more than offset such a substantial increase it was previously reported that the Board hired a Pharmacy Consultant to identify Pharmacy Benefit Managers known to deploy advantageous pricing, utilization management and overall transparency. This process presented a number of qualified candidates offering programs that would be expected to substantially reduce overall Rx spending. As a result, **effective January 1, 2016 Caremark will be replaced by Navitus as the Plan's Pharmacy Benefit Manager.**

During the month of December each covered employee in the PPO Plan will be receiving the following materials:

1. From the Trust Office a notice outlining the change to the prescription drug program and two new black/white Anthem ID cards on which any reference to Caremark has been replaced by Navitus as well as new program and contact information. These cards should replace the blue/white Anthem cards. If anyone needs more than two ID cards please contact the Trust Office (x-310). Whenever possible please be sure your service providers copy this new card.

2. A letter coming directly from Navitus to include an explanatory booklet and two Navitus ID Cards. These ID cards should replace any Caremark ID cards in your possession.

Presently the Plan's pricing structure through Caremark includes 3 Tiers: Tier 1 pays 80% for generic drugs (which are mandatory); Tier 2 also pays 80% for preferred brand name medications as determined by Caremark; and Tier 3 pays 40% for all non-preferred medications. This will change somewhat under Navitus whose 3 Tiers will be as follows:

Tier 1 - The Plan will pay 80% on all generic and preferred brand names as established in the Navitus Formulary list of preferred medications.

Tier 2- The Plan will pay 60% on generic or brand names for which there is at least one alternative in Tier 1.

Tier 3- The Plan will pay 40% of other non-formulary medications for which there is an alternative in Tiers 1 or 2. In the event filling a Tier 3 medication is mandated as written the Plan may only pay 40% of the cost of the lowest priced alternative, with the balance of the full cost of the prescribed medication to be paid by the participant.

Basically this change will be seamless for all participants who fill and re-fill their non-maintenance prescriptions at a major pharmacy chain as most all pharmacies in the CVS/Caremark national network will be in the Navitus network (**excluding Walmart**). What this means is that there is really little to do other than notify your dispensing pharmacy that Navitus is now the group's Pharmacy Benefit Manager and show your Navitus ID card which will tell them that Navitus pricing is to be procured instead of Caremark's. Further, it is expected that in most, but not all, instances pricing should be equal to or less than what was

being charged under Caremark pricing. Thus, it is reasonable to expect, but not guaranteed, that your co-pay should be no more than what you had been paying through Caremark, and hopefully less as there are various external reasons as to why a particular price could be higher than when last filled.

As is presently the case with Caremark, participants will be able to seek pricing and manage their prescriptions through the Navitus web site portal. Information on using this tool will appear in the general mailing to be made by Navitus.

THIS IS VERY IMPORTANT - Two areas that will require participant attention are:

All participants now using mail order and/or receiving specialty drug medication(s), as well as using a medication requiring "prior authorization" should be on the lookout for correspondence from Navitus in an effort to ensure continuity. It is also possible there may be guidance as to a need to seek a new prescription from your doctor for a lower Tier medication so that there will be no big surprise as to pricing should the change not be made.

1. **Mail order** - All participants using Caremark's mandatory mail order program for maintenance medications will need to have a new prescription for each medication submitted to MedVantx. Information on MedVantx will be forthcoming.

Note - For participants using the CVS/Caremark Maintenance Choice program offering 90 day supplies of maintenance medications to be picked-up at only CVS Pharmacies at mail order pricing, they will be able to utilize a similar 90-day retail program available through most major pharmacy chains within the Navitus network (excluding Walmart).

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USE ONLY PINNACLE PROVIDERS FOR MEDICAL OR DENTAL SERVICES IN MEXICO

All employees and their eligible dependents covered under the PPO Plan may now access medical and dental care in Mexico at **NO OUT-OF-POCKET COST** so long as only Pinnacle panel providers in Algodones, San Luis, Mexicali and Tijuana are used.

The objective is for you to have access to quality medical and dental services at a fraction of the cost of services in the U.S. There are no co-pays or deductibles, schedule your services today! To access services, simply present your Pinnacle healthcare ID card and your picture ID with any of the medical or dental providers contracted by Pinnacle.

Remember that to take advantage of these services you must seek services with the Pinnacle contracted providers. Provider listings may be accessed at the Trust Office, at the offices of IBEW Local 569 or via the Trust's web site (www.569trusts.org).

Arrangements have been made for the delivery of eligible medical/dental services as

follows:

Medical Benefits - All eligible expenses in accordance with the PPO Plan Schedule of Benefits.

Dental Benefits - All eligible expenses up to \$2,000 per covered person per calendar year. This includes benefits paid for services rendered by Delta Dental Dentists.

IF ANY COVERED EMPLOYEE OR DEPENDENT USES A MEDICAL OR DENTAL PROVIDER IN MEXICO OTHER THAN A PINNACLE PANEL PROVIDER THERE WILL BE NO COVERAGE UNDER THE PLAN AND THE PARTICIPANT WILL BE RESPONSIBLE FOR ALL BILLED CHARGES FROM THE SERVICE PROVIDER.

IMPORTANT - A separate plastic Pinnacle ID Card, which is NOT a replacement for the white/blue Anthem Blue Cross ID Card, must be presented to a Pinnacle medical/dental provider along with a pictured ID in order to receive covered services in Mexico. Further, the employee or dependent must be covered by the Plan at the time services are rendered.

Let Pinnacle take care of you, call Isabel Jaime at 760.355.3943, x 7343, or contact the Trust Office at x310.

BEST DOCTORS SAVES LIVES

It has been reported by the Best Doctors program that in their 25+ years of experience of reviewing self-reported medical cases **20+% of diagnoses** are clarified or changed, **60+% of recommended treatment plans** are clarified or changed, **38% of recommended surgeries** are totally unnecessary and **another 18%** of recommended procedures would not be the best one for the patient.

The Best Doctors program is available to all Covered Persons in the Plan A PPO Plan and all Kaiser Plans (Plans A, B & C). Under the PPO Plan there are certain incentives for participants who contact Best Doctors and complete the Inter-Consultation process. For Plan A PPO Covered Persons their calendar year deductible will be waived. Further, for services performed by and at a PPO Provider, all Eligible Expenses pertaining to the performance of any of the following elective surgical procedures will be paid at 100% (with no out-of-pocket cost) if a Best Doctors "Inter-Consultation" is completed **before** the procedure is performed: **back, hysterectomy, knee and hip replacement, obesity or bariatric, coronary artery by-pass graft, heart valve replacements, prostatectomy and lumpectomy/mastectomy.**

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 to qualify for this incentive subject to application of any other Plan limitations. In the event Best Doctors determines that an "Inter-Consultation" is not necessary, this incentive 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 Plans A, B or C at the time in order to qualify to receive the Best Doctors services offered by the Plan **at no cost to the participant**.

BEST DOCTORS HELPS TO SAVE LIVES AND CONTRIBUTE TO PARTICIPANTS ACHIEVING OPTIMAL MEDICAL OUTCOMES. BY PREVENTING UNNECESSARY, IMPROPER OR INAPPROPRIATE TREATMENT OVER THE LAST 4 YEARS PARTICIPANTS AND THE PLAN HAVE SAVED HUNDREDS OF THOUSANDS OF DOLLARS IN CLAIM COSTS WHICH HELPS TO KEEP THE HOURLY CONTRIBUTION RATE AS LOW AS POSSIBLE.

If there are any questions please contact the Trust Office (x702).

Pharmacy Benefits continued from Cover -

2. **Specialty drugs** - Currently, all specialty medications must be procured through Caremark's Specialty Rx program to be covered under the Plan. As of January 1, 2016 there will be a change from Specialty Rx to a new specialty medication service provider for which new prescriptions will be necessary.

Therefore, please always open any communication coming from Navitus or the San Diego Electrical Health & Welfare Trust as it may contain very important information about this transition, the pharmacy benefit program and/or the PPO Plan in general.

Please direct any questions at this time to the Trust Office (x702).

MAKING DIRECT PAYMENTS VIA DEBIT CARD REINSTATED

After a lengthy delay in the Trust Office being provided with updated equipment capable of accepting debit cards it is again possible for participants to make a Direct Payment to maintain Plan A and Plan B group health insurance coverage electronically in 2 ways:

- Using a computer or smart phone by accessing the Trust's web site (www.569trusts.org); or
- Using a debit card at the Trust Office

There will be no cost to the participant for using either of these services.

Direct Payments may also be made before the stated deadline for a particular month by mailing a check to the Trust Office or delivering a check to the Trust Office.

It should also be noted that the cost per hour utilized in calculating the Plan A Direct Payment amount has been increased for the first time in four (4) years from \$5.67/hr to \$5.95/hr.

When accessing the ACH Transfer tool the participant will be able to make a payment for either the current month and/or the following month. In order to make a Direct Payment for the following month the participant must be covered for the current month. If there is a need to make a Direct Payment for both months this can also be accomplished so long as the current month is paid first. Instructions for making an ACH Direct Payment are available through the Trust Office (x310).

SEVERANCE OF EMPLOYMENT REQUIRED TO COMMENCE EARLY RETIREMENT BENEFITS

The definition of "retirement" in the San Diego Electrical Pension Plan calls for the complete withdrawal from the electrical industry, craft or trade. Early retirement benefits may be available to participants between ages 55-64 who have accrued at least 10 vesting credits and meet all other applicable Plan requirements.

For all participants who are contemplating retirement from the San Diego Electrical Pension Plan prior to age 65 it is very important to be aware that prior to benefit payments commencing the Plan requires a notice of termination from their last employer if that employer is obligated to contribute to the Plan by virtue of a collective bargaining agreement or a participation agreement filed with the Trust Office. It should also be noted that this requirement of a bona fide separation also applies to work being performed outside the jurisdiction of IBEW Local 569 on behalf of an employer who is signatory to a collective bargaining agreement with IBEW Local 569.

At the same time, the Internal Revenue Service has made it clear that it views a retirement by an employee who returns to work for the same employer or another contributing employer within a short period of time to be a "sham" retirement. However, the Plan does permit a Retiree to collect their pension benefit and perform post-retirement employment for an employer that is signatory to a collective bargaining agreement with IBEW Local 569 within the electrical industry, craft or trade in the State of California for less than 40 hours in any calendar month.

If there are any questions relative to the above separation requirement and/or the permissibility of post-retirement employment under the Plan please contact the Trust Office (x-310).

CONTRACEPTIVE MEDICATION MAXIMUM BENEFIT

Under the PPO Plan the maximum benefit payable at 100% for a one-month supply of drugs and medicine for the purpose of contraception (i.e. birth control pills, Nova ring) for a covered female participant is \$55/mo or \$1,000 for implantation of a birth control device (i.e. Nexplanon, Mirena IUD) within a 3-5 year period. This means that regardless of the cost of a particular contraceptive drug or medication the maximum benefit amount payable should be no more than \$55 for a one month quantity, with any portion of the cost exceeding \$55 to be payable by the participant.

The Plan recently learned that Caremark has been mistakenly allowing the full cost of contraceptive drugs or medications (regardless of cost) with 100% being charged to the Plan, while the participant

would have had been charged a \$0 co-payment. This processing error has been corrected, thus the proper maximum benefit amount payable of \$55 has been reinstated and will continue through the rest of December 2015. However, it is important to note that Caremark will be replaced by Navitus as of January 1, 2016, meaning all contraceptive drugs and medications procured on or after January 1, 2016 will be processed and priced through Navitus who will be applying any and all internal PPO Plan maximum limitations such as the \$55/mo for a one month supply of contraceptive drugs and medications.

With respect to contraceptive drugs and medications in particular, if anyone covered by the PPO Plan is taking a drug or medication that costs more than \$55 for a

MEASURING THE VALUE OF THE LOCAL 569 INSIDE AGREEMENT H&W CONTRIBUTION RATE

The following schedule of current H&W contribution rates has been derived from the ERTS system's rate history going back to December 1, 2004, the date the Local 569 Inside Agreement contribution rate increased from \$5.28/hr to \$6.08/hr. Over the 11 years since then you will see how the need for increases totaling only \$.83/hr (just 14%) for Local 569 compares to the Inside Agreement contribution rates in other IBEW Locals in California:

Local Union	Rate	Effective Date	Increase
595 - Dublin	\$15.41	6/14	69%
6 - SF	\$13.25	6/15	62%
617 - San Mateo	\$13.21	6/15	113%
302 - Martinez	\$13.10	6/14	56%
332 - San Jose	\$12.98	12/12	106%
180 - Vallejo	\$12.95	6/11	82%
340 - Sacramento	\$11.38	6/15	95%
11 - LA	\$11.09	1/15	90%
234 - Castroville	\$10.95	1/16	59%
639 - San Luis Obispo	\$10.80	1/15	42%
551 - Santa Rosa	\$10.50	6/15	46%
684 - Modesto	\$10.30	1/15	n/a
100 - Fresno	\$10.25	7/15	83%
477 - San Bernardino	\$9.32	6/15	57%
413 - Santa Barbara	\$9.29	1/14	37%
428 - Bakersfield	\$9.19	12/13	54%
40 - LA	\$8.34	7/14	117%
441 - Santa Ana	\$7.49	1/15	53%
440 - Riverside	\$7.20	1/15	48%
952 - Ventura	\$7.12	1/15	45%
569 - San Diego	\$6.91	9/15	14%

Average Since 12/1/04 - 66%
Median Since 12/1/04 - 58%

The main reason for the substantially lower contribution rate for Local 569 has been the ability of the Health & Welfare Board of Trustees to implement effective programs focused on affording participants with comprehensive group health coverages with comparatively low out-of-pocket exposure in conjunction with what have been extremely effective cost-containment programs (Best Doctors, pre-screening claims for fraud, waste and abuse, mandatory generic drugs, CVS Minute Clinics, Pinnacle Mexican providers, online office visits, etc.). The end result of this success has been that over this 11 year period of time members have been able to keep a greater portion of their raises as opposed to allocating more of their raises to fund their health care. **If the Local 569 contribution rate had increased by the 66% average the current \$6.91/hr rate would be \$10.09/hr. That is true VALUE!**



one-month supply (That will be paid in full by the Plan) you either need to be prepared to pay the full cost above \$55/mo or consult your physician about switching to an alternative contraceptive drug or medication that costs \$55/mo or less.

If you have any questions please contact your claims examiner at the Trust Office (x-702).

SAN DIEGO ELECTRICAL INDUSTRY TRUSTS

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2016 ANNUAL INFORMATION UPDATE MUST BE RETURNED TO AVOID COVERAGE VERIFICATION AND CLAIMS DELAYS

REMINDER! Now that the Fall open-enrollment season for dependent group medical coverage to be effective for 2016 is coming to an end all Plan A participants are required to complete and return the "light green" Annual Information Update Form, in particular reflecting any change with respect to dependent group medical coverage to be effective as of January 1, 2016, recently sent out with a pre-paid, self-addressed, stamped envelope.

Completing and returning this Form to the Trust Office as soon as possible will prevent any delay in verifying dependent coverage or processing PPO Plan claims for services rendered on or after January 1, 2016. This Form contains basic claim form information necessary to permit the Trust Office to maintain accurate eligibility and PPO Plan related data.

VERY IMPORTANT - the Annual Information Update Form contains specific questions as to whether a spouse may work and/or have access to group medical coverage of their own. In the event the spouse has **available to them** a group medical plan for which the cost to the spouse would be \$100

or less per month, or in the event the spouse would receive any compensation whatsoever for declining or waiving available group medical coverage, the Plan is very specific to the extent the spouse will be ineligible for group medical coverage under the Plan. However, in the event of such an exclusion the spouse may still be eligible for Plan A dental and vision benefits.

When completing this Form please pay careful attention to the dependent spouse group medical coverage addressed above as there are specific time constraints under federal law to the extent a spouse may want or need to try to re-enroll in their own plan upon learning they had been ineligible under this Plan as far back as the beginning of the year.

Please direct any questions at this time to the Trust Office (x702).



POSTING OF ACTUARIAL PRESENTATION ON THE TRUST WEB SITE

On October 26, 2015 a special-called Local 569 membership meeting was conducted at which the Pension Plan's actuary outlined the current actuarial condition of the Plan and a series of Plan benefit modifications to be included in a Rehabilitation Plan to become effective as of October 1, 2016. At this meeting a request was made to provide a copy of the actuarial presentation to the membership.

As of the date of the membership meeting the Board of Trustees had not yet approved the final version of the Rehabilitation Plan, although a commitment was made to make a version of the presentation available once the Rehabilitation Plan is completed and approved by the Board. At that time the presentation will become accessible via the Trust's web site at www.569trusts.org. Please note that an ID and Password may be required to access the presentation.