CURRENTS

SAN DIEGO ELECTRICAL TRUSTS

Issue 81 May 2016

LOWER MAIL ORDER RX COSTS THROUGH MEDVANTX

Since January 1, 2016 PPO Plan participants started to fill their prescriptions through the Navitus pricing network instead of Caremark. The main purpose of this transition was to make available to plan participants all necessary medication(s) while substantially lowering the Plan's overall prescription drug costs. For the first three months the new program has delivered right in line with projections, albeit there have been some bumps in the road that had to be worked out within an average of over 2500 prescriptions being filled per month.

The most significant surprise has been both the service and pricing of MedVantx, the Plan's new mail order service provider, as their turnaround and delivery service has been significantly better than was Caremark's service and the pricing differential is extraordinary, even better than the pricing advantages of the new Retail 90 alternative through Navitus when compared to Caremark's "Maintenance Choice" program.

Examples of the difference between a participant's 20% co-pay for common 90 day generic supplies through MedVantx versus Caremark mail order are:

	CAREMARK	MEDVANTX	DIFFERENCE
Omeprezole (90 days)	$29.23 (11/15)	$ 3.82 (2/16)	-87%
Tamsulosin (90 days)	$15.66 (8/15)	$ 7.08 (2/16)	-55%
Pravastatin (90 days/180 qty)	$24.56 (12/15)	$13.45 (3/16)	-45%

With respect to service, between the day of placing the order through MedVantx to receiving it in the mail has been about 6-7 days where it was routinely 10-14 days through Caremark that pushed participants close to exhausting their supply of a medication.

If you are not using MedVantx, whereby medications are billed at **actual cost plus a fixed handling fee**, you are urged to call them at **1-866-744-0621** to get comparative pricing for your maintenance medications while keeping in mind that Retail 90 pricing at a particular pharmacy could be lower as of a particular day, but not as a rule. Their representatives will help you set up an account and move all of your maintenance prescriptions over to be filled when needed.

At the end of the day, where the cost of the very same prescription drugs are far lower than before through Caremark (retail, mail order or Retail 90) then both the participant and the Plan benefit, which helps to reduce the amount of future contribution rate increases to the members and contractors.

If you have any questions on using the new Navitus/MedVantx prescription drug programs please contact your claims examiner (x-702).

BEST DOCTORS SAVES LIVES AND REDUCE CLAIM COSTS

As has been reported by the Best Doctors program, for 2015 of all self-reported medical cases **25% of diagnoses** were clarified or changed, **52% of recommended treatment plans** were clarified or changed. Historically, **38% of recommended surgeries** are totally unnecessary and **another 18%** of recommended procedures would not be the best one for the patient. **Poor odds?**

For this group during 2015 there were a total of 49 calls to Best Doctors resulting in 21 Inter-Consultations and 30 requests to find an expert doctor. From within the treatment plans that were changed or modified **$519,512 in costs were avoided: $196,847** - Orthopaedic; **$103,419** - Hepatitis C; **$56,120** - Cardiac Arrhythmia; **$41,910** - Hysterectomy Avoided; **$5,557** - Weight Control; **$48,319** - Infectious Disease; and **$67,340** - Orthopaedic.

The Best Doctors program is available to all Covered Persons in the Plan A PPO Plan and all Kaiser Plans (Plans A, B & C) through which a diagnosis and/or recommended treatment plan may be validated by experts in each area. As a reminder, 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**.

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SUTTER HEALTH FACILITIES , MEDICAL CENTERS AND PROVIDERS NO LONGER PPO PROVIDERS

Sutter Health facilities and providers are known to be **considerably more expensive** than other hospitals, medical facilities and medical groups in the same geographic area. Whenever possible, ***for other than urgent or emergency care*** alternate PPO hospitals, medical centers and/or medical groups should be considered.

Please be advised that effective **January 1, 2017** Sutter Health medical facilities, which are largely in Northern California, ***will no longer be recognized as PPO network providers*** for this PPO Plan. However, *for other than urgent or emergency care* prior to that date you may wish to consider alternate PPO hospitals, medical centers and/or medical groups in order to avoid any interruption of service come January 1, 2017.

Should a participant utilize a Sutter Health facility on or after January 1, 2017 all eligible expenses will be processed by the Plan at a much lower co-insurance percentage (routinely 60% of what network pricing would be) and, more importantly, **the participant will be responsible to Sutter Health for the full balance due for charges expected to be higher than their discounted pricing as a network provider**. Further, there would be no point during a calendar year that the Plan would pay 100% of out of network provider charges, thus there would always be a balance due for charges from an out-of-network provider.

It is very important to always be sure that all medical providers or facilities from which you will be treated are active participant(s) in the Plan's PPO network at the time services are to be rendered. That said, PPO network Physician's offices should be aware of their responsibility to refer patients to only PPO network providers and/or facilities.

It is also possible to verify a provider is in the Anthem Blue Cross PPO network by going to www.anthem.com/ca.

PRESCRIPTION DRUG CO-PAYMENT ASSISTANCE

More and more pharmaceutical manufacturers are making co-payment assistance programs available to financially assist consumers when purchasing high cost medications. However, it is largely up to the consumer to be aware of such a program or to do the research on a manufacturer's web site, as well as becoming familiar with the eligibility requirements in order to qualify to receive assistance.

Many of these co-payment assistance programs require the consumer to register on the manufacturer's web site and be approved by meeting specific criteria. Assistance may come in the form of a fixed amount co-payment per prescription, a graduated fixed amount up to a maximum co-payment per prescription, a discounted percentage, or an immediate discount coupon applied at the point of sale.

The Trust Office welcomes participants taking advantage of any available co-payment assistance that may reduce their out-of-pocket cost. At the same time, it will be very helpful if the participant would contact the Trust Office and let their claims examiner know so that they can properly track their out-of-pocket costs for the current calendar year.

As a reminder, it never hurts to ask your doctor for samples whenever possible, especially if it is a new medication and the doctor is not sure of whether the prescribed dosage will either be well tolerated or deliver the desired result.

NEED TO REPORT SECONDARY GROUP MEDICAL COVERAGE - INCLUDING MEDICARE AND MEDI-CAL

It is standard throughout the group health insurance industry to co-ordinate coverage between group plans when more than one has a responsibility for the same medical claim(s). The purpose of this process is to cover up to 100% of eligible expenses by allocating responsibility between the group plans in a prescribed manner. This process not only minimizes or eliminates any out-of-pocket exposure to the participant, but it also greatly reduces overall plan costs.

The Plan Document requires the covered participants keep the Trust Office aware of the existence of any group health coverage(s) for the covered employee or any covered dependent, as well as any changes that may occur during a calendar year (new coverage or the loss of coverage). It is also important to understand that other group health plans could be through an insurance carrier (Blue Cross, Blue Shield, Aetna, Kaiser, Health Net, etc.) as well as Medicare and Medi-Cal.

In California Medi-Cal coverage is often available in relation to pregnancies and Medicare routinely

Report Coverage– continued from Page 4 –

CURRENT RETIREE ADDRESSES

There are a number of reasons the Trust Office needs a current address for all recipients of monthly pension benefits. They are: 1) To provide annual Form 1099'S for preparing income tax returns; 2) Sending quarterly statements of deposits and deductions; and 3) To send routine correspondence from and/or about the Pension Plan.

If mail is returned, and the Trust Office is unable to acquire a current address from another source, it is possible the person's pension benefit may be suspended until the Trust Office communicates with the benefit recipient and confirms their identity.

To all Retirees, Spouses or beneficiaries - Please make every effort to maintain a current address with the Trust Office at all times.

RECOUPING CLAIM OVERPAYMENTS

Under the PPO Plan overpayment of claims result for many reasons, although mostly due to the Trust Office learning of the existence of secondary coverage, where information on a claim may be misrepresented or erroneously presented, or upon learning that an individual was not actually eligible to be covered under the Plan after the claim has been paid. Additionally, unintentional mistakes during the adjudication process do occur from time to time.

Regardless of the reason for an overpayment, the Plan's "Right of Recovery" provision on page 59 of the current Summary Plan Description is very clear with respect to the fact that any overpayment must be recovered. In fact, an overpayment can be recovered from the participant or service provider as well by withholding future benefit payments on behalf of any member of the participant's family until the full amount of the overpayment has been recovered.

In the unfortunate event a claim overpayment issue may arise please understand that the Board of Trustees has a legal responsibility to recover it. In such an event the Trust Office will make a concerted effort to work with the participant or service provider on making mutually agreeable arrangements. Should those efforts fail then the above process of offsetting future claims will be applied.

UPCOMING JOURNEYMAN CLASSES FOR SUMMER 2016

For more courses, descriptions and registration information please see the online schedule at www.positivelyelectric.org.

CLASS SCHEDULE BY DATE

Start Date	Class Name/Description	Time
5/23/2016	Electrical Review	5-8pm
5/25/2016	Basic CPR, AED And First Aid For Adults	5-9pm
5/25/2016	Basic Microsoft Word & Excel	5-8:30pm
5/27/2016	Motor Controls	5-8pm
6/1/2016	Basic CPR, AED and First Aid For Adults Certification - Renewal	5-7:30pm
6/1/2016	Fire/Life Safety Prep for State Certification	5-8:30pm
6/2/2016	Voice-Data-Video Prep for State Certification	5-8:30pm
6/3/2016	Code Calculations: Conductor Ampacity	4:30-8pm
6/6/2016	CALCTP Acceptance Technician (AT)	5-8:30pm
6/6/2016	Electric Vehicle Infrastructure Training Program (EVITP)	5-8:30pm
6/6/2016	Structured Cabling For Fiber Optics Installations	5-8:30pm
6/7/2016	Fire Alarm Installations	5-8:30pm
6/9/2016	Structured Cabling for Copper Installations	5-8:30pm
6/15/2016	Basic CPR, AED and First Aid For Adults Certification - Renewal	5-7:30pm
6/16/2016	NICET Fire Alarm Certification Level I	5-8pm
6/17/2016	Welding Ii: Fabrication	5-8pm
6/21/2016	Soldering, Wire Types & Connectors	5-8pm
6/22/2016	Shades of Harassment for Employees	5-7pm
6/24/2016	Code Calculations: Raceway Fill	4:30-8pm
6/28/2016	Audio: Components, Connection Types, Signal Types, Flow and Alignment	5-8pm
6/29/2016	Basic CPR, AED And First Aid For Adults	5-9pm
6/30/2016	Conduit Bending 1	5-8:30pm
7/6/2016	Basic CPR, AED and First Aid For Adults Certification - Renewal	5-7:30pm
7/8/2016	Meter Use and Safety	4:30-8pm
7/11/2016	Electric Vehicle Infrastructure Training Program (EVITP)	5-8:30pm
7/11/2016	Electrical Review	5-8pm
7/12/2016	Residential A/V	5-8pm
7/19/2016	Audio/Video Controls	5-8pm
7/20/2016	Shades of Harassment for Employees	5-7pm
7/22/2016	Electrical Requirements for Healthcare Facilities, NEC Article 517	4:30-8pm
7/26/2016	CATV/RF Distribution	5-8pm
7/26/2016	NFPA 70E Arc Flash Hazard Awareness	5-8:30pm
7/27/2016	Basic CPR, AED And First Aid For Adults	5-9pm
8/12/2016	Transformer Testing & Meggering	4:30-8pm
8/26/2016	Confined Space Entry	4:30-8pm

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CATARACT LENS REPLACEMENT SURGERY MAXIMUM

The PPO Plan has been amended effective June 1, 2016 to establish a maximum payable amount of $10,000 per eye for charges relating to medically appropriate cataract surgery to replace the initial corneal lens performed while covered under the Plan. The maximum payable amount is intended to cover all expenses related to the procedure including, but not limited to, the cost of the surgeon, anesthesia, facility, laser incision process, and a standard single vision lens.

A cataract lens replacement is routinely considered to be medically appropriate if sight in an eye with a cataract cannot be corrected by glasses or contact lenses to see better than 20-40. However, there may be other circumstances that could qualify the procedure as being medically appropriate.

If there are any questions as to this procedure being medically appropriate or the procedure itself please contact the Trust Office (x-702).

Report Coverage– *continued from Page 2 –*

becomes effective if an individual has been totally disabled and receiving Social Security disability benefits for 2 years. The effectuation of either of these coverages for the covered employee or their covered spouse/dependent should be reported to the Trust office immediately to prevent any delays or difficulties when adjudicating claims. It should also be mentioned that intentionally withholding information as to secondary coverage from the Trust Office could constitute filing fraudulent claims which could result in potential financial and legal exposure to the participant.

Best Doctors – *continued from Page 1 –*

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 Best Doctors services offered by the Plan **at no cost to the participant.**

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

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.npdb-hipdb.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 http://www.calqualitycare.org/ which combines ratings for quality of care, patient safety and patient experience in an effort to help consumers make informed choices.