SOUTHERN CALIFORNIA IBEW – NECA TRUST FUNDS
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SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND

Important Notice to Participants

May 2011

The Trustees have taken action to amend the Southern California IBEW-NECA Health Trust Fund ("Plan") based on the requirements of the Patient Protection and Affordable Care Act (Health Care Reform) and the Mental Health Parity and Addiction Equity Act of 2008. The changes described in this notice are legally required changes that are effective **July 1, 2011.**

1. **Continued Grandfather Status.** The Board of Trustees of this group health Plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

   Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Board of Trustees, c/o The Southern California IBEW-NECA Administrative Corporation at either (323) 221-5861 or toll-free at 1-(800)824-6935. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

2. **Positive Enrollment.** Effective July 1, 2011, employees of the Plan establishing initial eligibility will be required to complete an enrollment form for health benefits in order to access health benefits. Even if an employee has established initial eligibility for health benefits, the only benefit an employee will have until he or she completes an enrollment form for one of the medical options and one of the dental options will be life insurance. The employee's failure to take appropriate action in enrolling for benefits will cause a reduction in the employee's Hour Bank Reserve without providing the employee with benefits of coverage, which would exist if the employee enrolled in the benefit options available to him or her on a timely basis.

3. Blue Cross PPO Plan Changes.

(a) **Lifetime Maximum -** Effective July 1, 2011, the lifetime maximum of $1,000,000 per person has been eliminated. The plan no longer has a lifetime maximum. The benefits are unlimited.

(b) **Out-of-Pocket Maximums** – Effective July 1, 2011, the current family out-of-pocket maximum will change from $12,500 to a maximum of $1,000 per eligible individual and $2,000 per family.

(c) **Hemodialysis Limit** – Effective July 1, 2011, the $350 maximum which currently applies to both in and out-of-network providers will now only apply to out-of-network providers. There will be no maximum for in-network providers.

(d) **Preventive Care Services** – Effective July 1, 2011, the annual deductible will be waived for preventive services received and the preventive services will be provided at no charge.

(e) **Physical and Occupational Therapy** – Effective July 1, 2011, there will be a $35 limit per visit for services received from an out-of-network provider. In addition, the number of visits is unlimited.

(f) **Chiropractic Benefit** – Effective July 1, 2011, there will be a $35 limit per visit for services received from an out-of-network provider. In addition, the number of visits is unlimited.

(g) **Elective Abortions** – Effective July 1, 2011, elective abortions will be covered under the surgery benefit.

(h) **Organ Transplant Travel and Donor Search Benefits** – Effective July 1, 2011, the organ transplant travel and donor search benefit will remain the same with the exception that the maximums have been removed. The benefit is now unlimited.

(i) **Bariatric Surgery Benefits** – Subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence (CME). Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity. Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric *CME* (Maximum payment will not exceed $3,000 per surgery for the following travel expenses incurred by the member and/or one companion: Transportation for the member and/or one companion to and from the CME. Lodging, limited to one room, double occupancy. Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded from coverage.)

4. Mental Health Parity –Effective July 1, 2011**,** Optum Health will no longer be the provider of mental health and substance abuse benefits. Compliant mental health and substance abuse benefits will be provided by the current medical vendors. The new mental health and substance abuse benefit schedules for each vendor are as follows:

(a) **United HealthCare HMO Plan**

Mental Health Services	**Plan Pays**
Inpatient, Residential and Day Treatment	
Medically Necessary Mental Health services provided at an Inpatient Treatment Center or Day Treatment Center	Same as medical plan Inpatient Mental Health Services Copayment
Outpatient Treatment	
When such Services are provided at the office of a Participating Practioner or at an Outpatient Treatment Center	Same as medical plan Inpatient Mental Health Services Copayment

Substance Use Disorder Services	**Plan Pays**
Inpatient, Residential and Day Treatment	
Medically Necessary treatment of Substance Use Disorders, including Medical Detoxification when provided at a Participating Facility	Paid in Full
Outpatient Treatment	
When such Services are provided at the office of a Participating Practioner or at an Outpatient Treatment Center	Paid in Full

(b) **Kaiser HMO Plan**

Inpatient Mental Health and Substance Abuse – No charge, unlimited days.

Outpatient Mental Health and Substance Abuse – $5 co-payment per visit, unlimited visits.

(c) **Blue Cross PPO Plan**

Inpatient Mental Health and Substance Abuse – 10% coinsurance for in-network benefits and 20% coinsurance for out-of-network benefits, subject to utilization review.

Outpatient Mental Health and Substance Abuse – 10% coinsurance for in-network benefits and 20% coinsurance for out-of-network benefits, subject to utilization review. Outpatient Visits will require preauthorization after the 12th visit.

5. United Health Care – Change in the Secure Horizons Chiropractic Benefit Co-Payment – The copayment will be reduced from $15 per visit to $5 per visit.

6. Extension of Coverage for Adult Children up to Age 26

The Affordable Care Act, a part of the health care reform law signed by President Obama on March 23, 2010, allows young adults to be covered by their parents' plan until they reach age 26. The law states that the extension of dependent coverage for children is effective for plan years beginning on or after September 23, 2010. **For this Plan, the law is effective July 1, 2011.**

Children who would lose eligibility as a dependent child on or after June 30, 2011 under the old eligibility rules (due to age or lack of full-time student status) will have their coverage continued until the last day of the calendar month in which they attain age 26 presuming the Participant retains eligibility under the Plan through that date. Please note that when the Participant loses coverage under the Plan, all children of the Participant lose eligibility under the Plan at the same time but both the parent and child have separate and distinct rights to continue coverage under COBRA.

One Time Special Enrollment

If you have a currently ineligible unmarried child who is under age 26, including a child that is currently on COBRA continuation coverage, that child may be eligible to enroll in the Plan effective July 1, 2011. This special enrollment opportunity applies to:

- Children whose coverage under the Plan already ended because they reached the limiting age and were not full-time students.
- Children who were previously denied coverage under the Plan for being over the limiting age and not being a full-time student.
- Children who are currently on COBRA continuation coverage because they lost eligibility under the Plan.

Any dependent children added during this Special Enrollment opportunity will have all the same benefits that are available to similarly situated individuals.

This Special Enrollment runs until July 1, 2011. To enroll a currently ineligible dependent child, you must request and complete the Special Enrollment Form, provide the supporting documentation as outlined, and deliver the documents to the Fund Office with a postmark no later than July 31, 2011. Coverage pursuant to this Special Enrollment shall be effective no earlier than July 1, 2011 even if the enrollment materials are received by the Fund Office before July 1, 2011. **Warning: Failure to timely enroll jeopardizes any coverage under this Plan for the currently ineligible child.**

This new coverage afforded under Federal Law only applies to the child who is enrolled.

The law also allows plans the option of denying coverage to dependents who are eligible to enroll for another employer-sponsored health plan OTHER than their parents' group health plans until the first Plan Year commencing in 2014 at which time this potential limitation of coverage is eliminated. This Board of Trustees has adopted this option until July 1, 2014. An Overage Dependent Certification form must be completed and

delivered to the Fund Office on or before a dependent turns age 19 together with the Special Enrollment Form.

This Notice is a Summary of Material Modifications ("SMM") within the meaning of Section 104 of the Employee Retirement Income Security Act of 1974. An SMM describes changes to the information provided in the most recent SPD. The SMM describes important changes to the Plan effective as of the date listed above. Please keep this SMM with your SPD for future reference. Please contact the Plan Office if you would like to request a copy of the Plan document, SPD or any SMM relating to the Plan.