

Puget Sound Electrical Workers Healthcare Trust

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Administered by
Welfare & Pension Administration Service, Inc.

July 1, 2015

TO: All Participants of the Puget Sound Electrical Workers Healthcare Trust (the “Plan”)

RE: Benefit Changes — Effective August 1, 2015

This is a summary of material modification describing benefit changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Trustees took action to make the following changes:

Overall Out-of-Pocket Maximum Changes

Effective August 1, 2015, the Plan’s Tier II annual out-of-pocket limit will increase from \$6,350 to \$6,600 per person and from \$12,700 to \$13,200 per family. The Tier II out-of-pocket limits now include your prescription drug co-payments and apply to your out-of-pocket costs for:

- All in-network Coinsurance
- In-network Emergency Room (ER) Copays
- In-network Deductible
- Pediatric Dental and Vision Copays and Coinsurance
- Prescription Drug Co-payments

Dental Benefits

The Plan's Dental Benefits include routine examination under Class I — Diagnostic Benefits.

Currently, routine examinations are limited to once in a 6-month period. Effective August 1, 2015, the limitation for routine examinations will be two routine examinations per calendar year, with the appointments separated by at least five months. This new limit is the same as the limitation for prophylaxis (cleaning).

Note: Not all participants are eligible for dental benefits. Please check your Summary Plan Description Booklet or contact the Administration Office for verification of dental eligibility.

Step Therapy Prescription Drugs

Your out-of-pocket cost for a brand name prescription drug – when a generic is available – is (1) the copay for the brand name drug plus (2) the difference in cost between the brand name and generic. Effective August 1, 2015, you won’t pay the cost difference when you get approval to use a brand name drug (instead of a generic) through the Step Therapy Program. Please refer to the Summary of Material Modification dated October 31, 2014 for a more complete description of the Plan’s prescription drug copays and for a more complete description of the Step Therapy Program.

Payments for Outpatient Dialysis Treatment

Due to the increasing cost of outpatient dialysis treatment, the Trust will implement changes to the coverage of dialysis treatment for End Stage Renal Disease (“ESRD”), effective August 1, 2015.

Enrollment in Medicare Based on ESRD Prevents Balance Billing. If you or your eligible dependent has been diagnosed with ESRD, you or your dependent may be eligible to enroll in Medicare Part A and B. Although you are not obligated by the Trust to enroll in Medicare, Enrolling in both Parts A and B will help protect you from being balance billed by providers of ESRD dialysis services.

Currently, the Trust pays charges for outpatient dialysis as follows:

1. If the provider is a preferred provider, the Trust pays the provider based on the discounted preferred provider amount, subject to deductible and coinsurance, and the provider may not “balance bill” you for the difference between the discounted amount and their billed charges.
2. If the provider is not a preferred provider, the Trust payment is based on the Usual, Customary and Reasonable (UCR) rate for outpatient dialysis, subject to deductible and coinsurance, but the provider may balance bill you for any amount in excess of UCR.

After this change, when you or your dependent is enrolled in Medicare (or is simply eligible for Medicare) based on ESRD, the following payment rates will apply for both preferred and non-preferred providers:

- When Medicare becomes the “Secondary Payer” under the Medicare rules (usually beginning with the 4th month of ESRD treatment) the Trust, as a “Primary Payer” will pay claims for ESRD services at 150% of the then current Medicare allowable amount. These services will not be subject to deductible or coinsurance. **Note:** This rule applies when you are eligible for Medicare, even if you do not enroll in Medicare. Unless you are enrolled in Medicare (as noted above), the provider may balance bill you for the difference between 150% of the Medicare allowable amount and the provider’s billed charges.
- When Medicare later becomes the Primary Payer (usually beginning with the 34th month of treatment for ESRD), the Trust, as Secondary Payer, will pay claims for ESRD services at 100% of the then current Medicare allowable amount (subject to coordination of benefits with Medicare). These services will not be subject to deductible or coinsurance. **Note:** This rule applies when you are eligible for Medicare, even if you do not enroll in Medicare. Unless you are enrolled in Medicare (as noted above), the provider may balance bill you for the difference between the Medicare allowable amount and provider’s billed charges.
- Coverage for all other ESRD dialysis services will remain unchanged.

The Trust may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may provide for a different payment rate for ESRD services than described above. But in no circumstances will the contract allow for a payment less than the payments listed above. Any contractual agreement and/or change in payment terms with a provider of ESRD services will be at the sole discretion of the Trust.

Summary of Benefits and Coverage

The Trust is required to provide a **Summary of Benefits and Coverage (SBC)** to all participants and beneficiaries. The enclosed SBC is for the Plan in which you are currently enrolled and reflects the benefit changes outlined in this notice. *Please note, the SBC furnished to the participant will be considered provided to dependents unless the Plan has been advised of a different address for dependents.*

It is important to note that the SBC is only a **summary** and does not replace the Summary Plan Description (Plan booklet). Included in the SBC are “coverage examples”, which estimate what the plan benefit would be under two common medical situations. If you are eligible or enrolled in Medicare or have primary coverage through another group health plan, this plan’s benefits will be coordinated with that other plan and differ from what’s indicated in the SBC, and the coverage examples. **The SBC is not intended to be a cost estimator and should not be used to estimate your actual costs.**

A **Uniform Glossary of Terms** has also been published by the government. This document is intended to describe terms commonly used in health insurance coverage, such as "deductible" and "copayment" Both the SBC and the Uniform Glossary of Terms have been posted to the Trust’s website at www.psewtrusts.com or you can call the Administration Office at the number below.

Please keep this important notice with your Plan Document/Summary Plan Description for easy reference to all Plan provisions. If you have any questions about these changes, please contact the Administration Office at (866) 314-4239, option 0.

Board of Trustees Puget Sound Electrical Workers Healthcare Trust

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