

**SAN FRANCISCO ELECTRICAL WORKERS HEALTH &
WELFARE PLAN
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October 23, 2008

To: All Active and Retired Members Covered Under the Indemnity Plan

From: Plan Office

Re: Blue Shield Shared Advantage Program

As we announced in our June 2008 Notice on Plan Changes, the First Health Preferred Provider Network, Special Transplant Benefit Management, and Case Management will be replaced with **the Blue Shield Shared Advantage Program effective November 1, 2008. These changes affect Indemnity Plan members and dependents only.** This change, however, has no effect on mental health/substance abuse benefits that remain available through OptumHealth (formerly known as PacifiCare Behavioral Health).

The Trustees made this decision after reviewing a claims analysis that revealed the potential for significant savings resulting from a broader network of participating providers and deeper provider contract discounts. This change is expected to benefit both participants and the Plan. Since Blue Shield provides both claims imaging and electronic claims pricing services that are now being performed by two separate entities, this change will streamline EISB's claims processing procedures and improve overall service to members and their dependents.

We have enclosed your new Plan identification cards that you can begin using effective November 1. The new cards include a unique identification number that has been assigned to you.

Administrative Changes

Shared Advantage is a self-funded shared administration program. Blue Shield of California manages the provider network, including network contracting, pricing and reformatting of in-state and out-of-state claims, while EISB manages the participant benefits, eligibility, and claims adjudication. Blue Shield provides administrative services only and will not assume any financial obligation with respect to claims.

EISB will continue to:

- Maintain participant eligibility and benefit records

- Process claims to determine eligible benefits and participant liability
- Mail Explanations of Benefits (EOBs) and checks to in-state providers and participants
- Provide customer service to covered individuals and in-state providers
- Address provider inquiries/requests for review on behalf of Blue Shield

Blue Shield will:

- Receive and price all claims from providers
- Send priced claims to EISB
- Pay claims to out-of-state providers
- Provide concurrent review for inpatient services
- Provide retrospective review for inpatient and facility out-patient services
- Provide pre-service review on select services

California providers will submit claims for dates of service on and after November 1, 2008 to Blue Shield of California, P. O. Box 272540, Chico, CA 95927-2540. Out-of-state providers will submit claims for dates of service on and after November 1, 2008 to the local Blue Cross/Blue Shield of the state where services were rendered. Claims incurred before November 1 should be sent to EISB.

Special note for retired, Medicare-eligibles:

For all retired, Medicare-eligible members, we are working on a process to allow Medicare to submit claims directly to Blue Shield/EISB for final benefit review and payment. Until that process is set up, please instruct your providers to continue to submit their claims to Medicare first. Once Medicare has completed processing and issues the Medicare Explanation of Benefits (EOMB), you or your provider will then need to submit the claim and EOMB, directly to Blue Shield to ensure proper claims handling. The address for claims submissions is listed in the preceding paragraph and on the back of your Member Identification Card.

Benefit Changes

Enclosed is a Summary of Material Modifications that describes in detail the benefit changes that were adopted by the Board of Trustees to provide an incentive for members to utilize the new network and to generate additional cost savings to the Plan. The following represents a short summary of the changes that take effect November 1, 2008 unless noted otherwise:

- 1) An additional 20% coinsurance charge for out-of-network providers has been implemented. Coinsurance is the percentage of a Covered Charge that the member must pay (after any deductible is met). The coinsurance percentage for out-of-network providers will be 40% and will remain at 20% for in-network providers (also known as Preferred Providers). Since 96% of the First Health network providers also participate in the Blue Shield Shared Advantage Program, this change should not affect many members. Also note that the Preferred

- Provider coinsurance percentage may be applied to services rendered by an out-of-network provider for certain emergency care or if the Plan Office determines that the member or his or her dependent was not able, despite reasonable efforts, to secure treatment by a Preferred Provider.
- 2) Currently, the Plan generally provides for reimbursement of 100% of the first \$5,000 of Hospital Covered Charges. Beginning November 1, 2008, this \$5,000 Hospital benefit will apply to certain outpatient Hospital Covered Charges of Preferred Providers only, and 80% reimbursement of certain Hospital Covered Charges for providers that are not Preferred Providers. However, if emergency care is needed in a facility that is not a Preferred Provider, benefits will be reimbursed at the higher Preferred Provider level. Inpatient Hospital charges will be covered at 80% (if a Preferred Provider) and 60% (if not a Preferred Provider), and at 100% once the \$1,000 calendar year out-of-pocket maximum has been reached.
 - 3) Before November 1, 2008, benefits were paid at 100% for the remainder of a Calendar Year once a covered individual incurred \$5,000 in Covered Charges. Since Covered Charges include reimbursements at both the 80% and 100% levels, an individual was relieved of out-of-pocket charges for the year to the extent that the individual benefited from the Plan paying the first \$5,000 of Hospital charges at 100%. With the exception of the \$5,000 outpatient Hospital benefit described in paragraph 2 above and preventative cancer screenings that are reimbursed at 100%, the Plan will now pay other Hospital and Medical Covered Charges incurred during the year at 100% only after a covered member or dependent has accumulated \$1,000 of out-of-pocket expenses, regardless of whether the charge is in-network or out-of-network.
 - 4) Acupuncture and Chiropractic services will each be limited to a maximum of 30 visits per calendar year effective January 1, 2009.

Preferred Providers

Preferred Providers include physicians, hospitals, ambulatory surgery centers, certified registered nurse anesthetists, dialysis centers, and home health care and home infusion agencies that have contracted with Blue Shield. They have agreed to furnish services and accept as payment in full the amount paid by the Plan based on a negotiated fee arrangement for services rendered, plus any applicable deductible, coinsurance, or amounts in excess of a specified benefit maximum. To find a provider, simply go to www.blueshieldca.com and:

1. Click "Find a Provider."
2. Select "Find a Doctor" or "Find a Hospital or other facilities."
3. Choose a Plan: In the drop down menu, select "Blue Shield PPO."
4. Choose a search type and enter criteria; in this section you can select the provider/facility type, specialty or search by name.

5. If you have a provider preference based on gender or language, you can narrow the search criteria under “Find a Doctor.”
6. Enter your location and press “search.”
7. Contracted providers meeting your selected search criteria will be displayed.

Because Preferred Providers agree to accept the Plan’s payment, plus your payment of any applicable deductible and coinsurance, you are not responsible for amounts that exceed the negotiated fee for Covered Services. If you receive treatment from a provider who is not a Preferred Provider, you will be responsible for the difference between the amount charged for Covered Services and the amount that is paid by the Plan. It is, therefore, to your advantage to obtain medical and Hospital services from Preferred Providers whenever possible.

Out of Area (BlueCard) Program

When covered services are received in a state other than California, the member’s copayment will be based on the local Blue Cross/Blue Shield (or Host plan’s) arrangement with a provider. Again, your copayment is higher when you receive treatment from a provider that is not a Preferred Provider.

If you live outside California, or you require treatment while traveling outside of California, call the toll-free BlueCard Access number at 1-800-810-BLUE (2583) to locate physicians and facilities that participate with the local Blue Cross/Blue Shield Plan (Host plan). You may also access participating provider information through the Blue Shield website at www.blueshieldca.com:

1. Click “Find a Provider.”
2. Choose “providers Outside of California.”
3. Enter XEL, the three alpha character that appears before your unique ID number on your card.
4. Enter city/state/zip or street address into search fields to locate nearby providers.
5. Select provider/facility type.

Be sure to present your Plan identification card at the time of treatment. The provider or hospital will then verify your eligibility and coverage information by calling BlueCard Eligibility. The three alpha prefix, XEL, that appears on your ID card will be used by the local Blue Plan to correctly route your claims through the system to Blue Shield of California and then to EISB for adjudication. The claim will be processed based on the local Blue Plan’s U&C (Usual and Customary) and pricing rules, and in accordance with the SFEW Plan’s benefit provisions.

Benefits will also be provided for Covered Charges received outside of the United States through the BlueCard Worldwide Network. If you need urgent care while out of the country, call either the above toll-free BlueCare Access number, or call collect at 1-804-673-1177 available 24 hours a day, seven days a week. Again, you can also access provider information through www.blueshieldca.com by choosing “Coverage Outside the

USA.” This time you will be prompted to enter your entire unique identification number including the three alpha prefix.

When treatment is received outside California, you may be asked to pay for your applicable copayment and plan deductible at the time you receive the service. However, once your claim has been adjudicated, you will receive an EOB which will show your payment responsibility.

Benefit Management Program

The following services that are currently provided through First Health will be administered by Blue Shield of California, effective November 1, 2008. Blue Shield will work with First Health to ensure a smooth transition of all case management services that are currently in progress.

Prior Authorization/Pre-Admission Review: Before services are provided, you or your provider can determine whether a procedure or treatment program is covered, or if an alternative service is recommended by contacting Blue Shield at 1-800-343-1691. Failure to do so may result in a denial of benefits if, for instance, as a result of a Retrospective Review (described below) it is determined that a procedure or treatment plan is not medically necessary or is not a Covered Charge. Services for which Prior Authorization Reviews are recommended include all hospital and skilled nursing facility admissions, home health care, admissions into an approved hospice program, clinical trial for cancer, durable medical equipment, surgery that may be considered cosmetic rather than reconstructive in nature, arthroscopic surgery of the temporomandibular joint (TMJ), dialysis services, special transplant benefits, and bariatric surgery.

Concurrent/Continued Stay Review (Acute, Skilled, Rehabilitation): This is a review process that is coordinated by the case management staff during a course of hospitalization to assess the medical necessity and appropriateness of continued confinement at the requested level of care.

Retrospective Review: In the absence of a Pre-Admission Review, a Retrospective Review is performed to determine medical necessity, the appropriate level of care, the quality of health care, and to assess whether to refer to case management.

Please contact the Plan Office at 415-263-3670 if you have any questions regarding the new PPO program offered through Blue Shield Shared Advantage.