Laborers' Metropolitan Detroit Health Care Fund

Local #1076 and #1191

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IMPORTANT NOTICE FOR ALL PARTICIPANTS

TO: ALL PARTICIPANTS OF THE LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND (LMDHCF or FUND)

RE: SUMMARY OF MATERIAL MODIFICATIONS – *EFFECTIVE MARCH 1, 2016*
PRESCRIPTION DRUG CHANGES
NEW OUT-OF-POCKET MAXIMUM CHANGES

Dear Participants:

This is a summary of changes to the Fund's prescription drug program, and your maximum out-of-pocket expenses. Both changes are ***effective March 1, 2016.***

Below we explain these changes and the reasons for them.

I. Non-Medicare and Medicare Participants

Effective March 1, 2016, non-Medicare and Medicare participants will have different prescription drug benefits under the Fund.

A. Non-Medicare Participants - Active and Retired

Non-Medicare participants' prescription drug benefits will change from the current Three-Tier Program to a Five-Tier Program, as described below and in the attached Benefit Summary:

Current Program – Three Tier:

Tier 1 – Generic Drugs	$20 copayment
Tier 2 – Preferred Brand Drugs	$50 copayment
Tier 3 – Non-Preferred and Specialty Drugs	$70 copayment

New Program – Five Tier:

Tier 1 – Preferred Generic Drugs	$20 copayment
Tier 2 – Preferred Brand Drugs	$60 copayment
Tier 3 – Non-Preferred Brand Drugs	$100 copayment
Tier 4 – Preferred Specialty Drugs	20% copayment with a maximum copayment of $200
Tier 5 – Non-Preferred Specialty Drugs	25% copayment with a maximum copayment of $300

PLEASE NOTE: Both the ninety (90) day mail order and ninety (90) day retail pharmacy options are still available after this prescription drug benefit change. As before, you'll be charged two (2) times the applicable copayment (based on the new copayment schedule) whether you purchase a ninety (90) day prescription through mail order or a retail pharmacy (*e.g.* Rite-Aid or Walgreens).

The copayment for a ninety (90) day prescription for a generic drug, for example, would be $40 (i.e., two-times the cost of the normal $20 copay for a generic drug).

B. Medicare Participants – Retired And Disabled

Medicare participants' prescription drug benefits will also change from the current Three Tier Program to a Five Tier Program, as described below and in the attached Benefit Summary. But, Medicare participants will be part of the "*Prescription Blue Group PDP"*. The *Prescription Blue Group PDP* is often referred to as "Part D of a Medicare Advantage plan."

The new Five-Tier prescription drug program for Medicare participants will be as follows:

Current Program – Three Tier:

Tier 1 – Generic Drugs	$20 copayment
Tier 2 – Preferred Brand Drugs	$50 copayment
Tier 3 – Non-Preferred and Specialty Drugs	$70 copayment

New Program – Five Tier:

Tier 1 – Preferred Generic Drugs	$20 copayment
Tier 2 – Non-Preferred Generic Drugs	$20 copayment
Tier 3 – Preferred Brand Drugs	$50 copayment
Tier 4 – Non-Preferred Brand Drugs	$70 copayment
Tier 5 – Specialty Drugs	$70 copayment

PLEASE NOTE: Both the ninety (90) day mail order and ninety (90) day retail pharmacy options still are available after this prescription drug change. As before, Medicare individuals still will be charged two (2) times the applicable copayment (based on the new copayment schedule) whether they purchase a ninety (90) day prescription through mail order or

a retail pharmacy. The copayment for a ninety (90) day prescription for a generic drug, for example, would be $40.

1. How the New Prescription Drug Plan Works for Medicare Participants

If you're enrolled in Medicare and receiving Fund benefits, you'll receive a "Pre-Enrollment Kit" (Kit) from BCBSM in mid-January 2016. The Kit will contain detailed information about the new prescription drug plan. The Kit will include a BCBSM letter and summary of pharmacy benefits.

The Kit also will include an "Opt-Out Form." This "opt-out" is a legal requirement that allows you to "opt-out" of the prescription drug program, if you choose.

But, if you "opt-out," you'll be permanently terminated from the LMDHCF plan for *all* health care benefits – not just prescription drug benefits. If you do nothing – that is, if you don't opt-out – you'll automatically be enrolled in the Fund's new prescription drug program and your Fund health care benefit plan will continue.

C. BCBSM ID Cards

1. Non-Medicare Participants

Non-Medicare participants *will not need or receive* a new BCBSM ID card (unless your family has a combination of Medicare and non-Medicare participants, as described below). Your current ID card will continue to work. The new copayment levels will automatically be applied when you use your current ID card.

2. Medicare Participants and Spouses/Dependents

Each Medicare participant and any spouse and/or dependent will receive two (2) new ID cards – one (1) for prescription drug benefits, and one (1) for all other Fund benefits.

So, if a husband and wife both collect Medicare benefits, each will get their **own, separate** prescription drug-only ID card, and a separate ID card for all other Fund benefits.

PLEASE NOTE: If you're Medicare-covered, you should continue to use your Medicare card – just as you do now – in conjunction with your BCBSM ID card for medical services.

3. Families Where Some Members are Medicare Covered and Some Are Not

Families with both Medicare and non-Medicare members will receive *new* ID cards.

Individuals enrolled in Medicare and receiving Fund benefits will receive a *new* ID card for pharmacy benefits and a separate ID card for all other health care benefits (see the explanation for Medicare Participants above).

Fund-covered spouses and/or dependents not enrolled in Medicare will be issued one *new* BCBSM ID card with a different identification number in the name of the non-Medicare participant. This single, new card will cover both prescription drug and non-prescription drug health care benefits.

D. ID Card Mailing and Using Your New Card

ID cards should be mailed by mid-February 2016. So, starting March 1, 2016, please present any new ID card to your pharmacist and your other health care providers. (Remember though, if you're a non-Medicare participant and have no family members on Medicare, your current ID card will work even after March 1.)

Your old BCBSM ID card ***won't*** work after March 1, 2016 if you're enrolled in Medicare and receiving Fund benefits. So, you should call the Fund Office at (517) 321-7502, or Toll Free at (800) 228-0048, before the end of February if you haven't received your new BCBSM ID card(s).

II. MAXIMUM OUT-OF-POCKET COSTS UNDER THE AFFORDABLE HEALTH CARE ACT (ACA)

Effective March 1, 2016, there are changes in the amount you could pay for health care benefits. These new out-of-pocket maximum amount changes apply the same to ***all*** Fund participants—whether you are a non-Medicare or Medicare participant.

ACA limits on your out-of-pocket costs are adjusted annually. These limits apply separately to **in-network** costs and **out-of-network** costs. The current annual ACA out-of-pocket maximums – for both **in-network** and **out-of-network –** are $6,200 for an individual and $12,500 for a family.

Effective March 1, 2016, ACA maximum **in-network** and **out-of-network** out-of-pocket cost limits each are raised to $6,600 for an individual and $13,200 for a family. ACA out-of-pocket maximums apply to co-insurance and/or copayments for **medical** and **pharmacy benefits only.**

It's unlikely you'll ever reach these ACA limits. Why? Because the Fund limits most participants' out-of-pocket costs at a level lower than these ACA levels, *e.g.*, the Fund currently has a $1,000 co-insurance maximum per family for medical services and fixed copayments for pharmacy benefits.

Still, these ACA annual out-of-pocket maximums limit the amount you *could* pay during a calendar year for your share of the cost of covered services. These ACA limits help you plan for health care expenses and provide you with extra financial protection.

III. WHY WE MADE THESE CHANGES

Quite simply, we made these prescription drug changes because it was fiscally prudent and consistent with our duty to address the hard issue of ever-rising prescription drug costs.

We understand that any change is difficult. But, these prescription drug changes were economically necessary.

The ACA changes are required by law.

Sincerely,

BOARD OF TRUSTEES

LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND