DETROIT & VICINITY TROWEL TRADES
Health and Welfare Fund
P.O. Box 99490 • Troy, MI 48099-9490 • Phone (248) 828-6000 • Fax (248) 828-6001

IMPORTANT NOTICE

TO: ALL ELIGIBLE PARTICIPANTS

RE: PLAN CHANGES – *EFFECTIVE JUNE 1, 2019*

DATE: MARCH 29, 2019

Dear Participants:

As you may know, the Board of Trustees carefully and routinely reviews the Plan benefits and eligibility to assure that the best affordable benefits are provided. As a result of this review, the following changes are being implemented. The Trustees have determined these changes are necessary to protect the financial integrity of your Fund and the ability to continue to provide benefits into the future. Please read this notice carefully and keep it with your Summary Plan Description (SPD) booklet for future reference.

This is a summary of changes to the Fund's medical and prescription drug program, your maximum out-of-pocket expenses, and self-payments.

Loss of ACA Grandfathered Status

As a result of the changes being made, the Fund will cease being a "grandfathered" health plan for purposes of the Affordable Care Act (i.e., the health care reform law). As described below, there are some benefit coverages required under the Affordable Care Act that did not apply to "grandfathered" health plans. As a "grandfathered" health plan, the Fund had been exempt from those changes until now. Because the Fund will no longer be a "grandfathered" health plan as of June 1, 2019, these additional benefit coverages are required by the Affordable Care Act and will apply to the Fund, for In-Network providers.

- Coverage of **preventive care**, without participant cost-sharing, for In-Network provider claims - Preventive services include annual physicals, immunizations and contraceptives. For more information about what services are considered **preventive care**, please see https://www.healthcare.gov/coverage/preventive-care-benefits/.
- **External review** – under some circumstances, you will have the right to take your appeal to an independent third party for review, which, if applicable, will be explained to you in your appeal denial letter. For more information about **external review**, please see https://www.healthcare.gov/appeal-insurance-company-decision/external-review/.
- Coverage of routine costs associated with certain **clinical trials**. For more information, please see Q&A-3 at https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/aca_implementation_faqs15.html.
- Additional **patient protections** – right to choose a primary care provider designation, OB/GYN access without a referral, and coverage for out of network emergency department services.
- **Limitations on out-of-pocket maximums**. There is a statutory maximum on out of pocket expenses that an individual (or family) can incur in a year on "essential health benefits". Once that maximum limit is met, the individual (or family) will have no additional out of pocket expenses (e.g., deductible, coinsurance, copays) that year for "essential health benefits".

For 2019, the out of pocket maximum has been set at $7,900 for self-only coverage and $15,800 for family coverage. These allowable maximum amounts are indexed to inflation and change each year. You will be informed when changes are made.

Medical

- **Non-Medicare Participants and Dependents - Actives, Non-Bargaining Unit (Participation Agreement), Early Retirees, Surviving Spouses and Permanent & Total Disability**
    - Beginning with medical claims incurred on and after June 1, 2019, we are pleased to announce that the Fund will be moving to the Blue Cross Blue Shield of Michigan PPO provider network (BCBSM). BCBSM will be replacing the Cofinity/PHCS provider networks. These changes allow our participants access to the largest number of in-network providers both in the state of Michigan and while traveling out the state.

    - New ID cards will be issued directly by BCBSM and are to be used on or after June 1, 2019.

- **Medicare Participants and Dependents - Retirees, Surviving Spouses and Permanent & Total Disability**
    - Beginning July 1, 2019, all Medicare eligible participants not already enrolled in the BCBS Medicare Advantage (MAPD) plan must be enrolled and making the required monthly self-payment in order to continue coverage in the Fund

    - For those not yet enrolled, new ID cards will be issued directly by BCBSM after enrollment documents have been submitted and processed.

Prescription Drug Program

- **Actives and Non-Bargaining Unit (Participation Agreement)**
    - Beginning with prescription drug claims incurred on and after June 1, 2019, Express Scripts through BCBSM will be replacing Sav-Rx as the Pharmacy Benefit Manager (PBM) for Active Participants.

    - Since the Health Fund will no longer be a "grandfathered" health plan after June 1, 2019, the Trustees have also decided to eliminate the large co-insurance requirement that applied to prescription drugs after a certain dollar amount has been paid out of pocket. Instead, the Trustees have adopted a more traditional prescription drug benefit outline:

        - Generic drugs
            - $5 copay for 30-day/retail supply; No charge for 90-day supply/mail order
        - Preferred brand drugs
            - 30% copay ($5 minimum) for 30-day supply/retail or 90-day supply/mail order
        - Non-preferred brand drugs
            - 30% copay ($5 minimum) for 30-day supply/retail or 90-day supply/mail order

- **Medicare Participants - Retirees, Surviving Spouses and Permanent & Total Disability**
    - Beginning July 1, 2019, all Medicare eligible participants not already enrolled in the BCBS Medicare Advantage (MA) plan must be enrolled and making the required monthly self-payment in order to continue coverage in the Fund. If you are or become eligible for Medicare, the Fund will continue to offer you a Prescription Drug Program through the BCBS Medicare Advantage Plan.

Non-Medicare participants - Early Retirees, Surviving Spouses and Permanent & Total Disability will no longer have the $100 ($1,500 P&T Disability only) prescription drug benefit as part of their benefit coverage after June 1, 2019.

Other Changes to Prescription Drug Program - Actives and Non-Bargaining Unit (Participation Agreement) Participants

Medical Specialty Drugs

Effective June 1, 2019, the Fund will require prior-authorization for select specialty pharmaceutical drugs administered in BCBSM approved locations, such as a hospital, doctor's office, clinic, or home drug administration.

Under the Fund's current Plan, the cost of the drug is covered subject to your deductible and co-insurance obligations. On and after June 1, 2019, your physician must contact BCBSM to obtain prior-authorization. If prior-authorization is *not sought and received* from BCBSM, you may be responsible for the full cost of the specialty drug without regard to your deductible or co-insurance.

Please call the **Clinical Help Desk after June 1, 2019** at **1-800-437-3803** to check what drugs are covered under Medical Specialty Drugs.

Step-Therapy for certain Prescription Drugs

Beginning June 1, 2019, the Fund will institute step-therapy for some prescription drugs. Prescription drugs are generally provided under the terms of the Plan based on the applicable co-pay tier and the formulary used by the Fund's pharmacy benefits manager based on prescriptions written by your doctor.

Under the new step-therapy program, you and your doctor will be required to try certain alternative drugs before using more expensive ones. If you and your doctor do not follow this approach, the cost of your prescribed drug may not be covered by the Plan. Therefore, you should consult with your doctor when receiving a prescription.

Exclusive Specialty Drug Program

The prescription benefit design now requires you get specialty drugs from the exclusive pharmacy network. AllianceRx Walgreens Prime is the exclusive specialty pharmacy network provider. Specialty drugs typically require special handling, administration and monitoring and the exclusive specialty program allows for streamlined care for our members.

Smart90 Program

If a member is getting a 90-day fill of a maintenance medication it must be filled either through Express Scripts or Walgreens after 2 grace fills at any network retail pharmacy. This allows the Fund to ensure the most cost-effective avenue of delivery of maintenance medications.

Please visit "bcbsm.com/pharmacy" for more information about the pharmacy benefits through BCBSM.

Continuing Eligibility and Hour Bank - Active Participants

Beginning with the June 1, 2019 work month (September 2019 eligibility month) the requirement for Active participants continuing eligibility rule will be based on 130 hours per month and the hour bank maximum will be increased to 520 hours. Currently active participants continuing eligibility is based on 120 hours with a maximum hour bank of 480 hours.

Self-Payment Rates

The current self-pay rates for all participants - Active, Early Retirees, Medicare Retirees, Surviving Spouses and Permanent & Total Disability participants have been unchanged for many years. In some cases, these self-pay rates have not increased in more than a decade although the hourly contribution rate made on behalf of Active Participants has increased to help offset the cost of providing quality benefits and medical inflation.

- **Active Participants Self-Pay Rates**
  - **Beginning with the June 1, 2019 work month (September 2019 eligibility month),** all self-payments will be based on a 20% discount from the active contribution obligation (see Self-Pay chart on page 5).

- **Non-Medicare Retirees, Non-Medicare Widows and Non-Medicare Permanent & Total Disability Self-Pay Rates**
  - **Beginning with the July 1, 2019 eligibility month,** all self-payments for those are not eligible for Medicare will be based on a 20% discount from the active contribution obligation (see Self-Pay chart on page 5).

- **Non-Bargaining Unit (Participation Agreement)**
  - All self-payments will continue to be 160 hours multiplied by the current contribution rate for monthly eligibility.

- **Medicare Retirees, Medicare Widows and Medicare Permanent & Total Disability Self-Pay Rates**
  - **Beginning with the July 1, 2019 eligibility month,** all Medicare eligible participants must enroll in the BCBS Medicare Advantage (MAPD) plan with self-payments rates equal to the MA premium rate (see Self-Pay chart on page 5).

of benefits submit self-payment before due date of 25th each month

Weekly Disability Benefits and Continuation During Short Term Disability (Loss-of-Time Credit)

Effective July 1, 2018, you must submit an application to the Fund Office for weekly disability benefits and loss-of-time credits from the onset of your disability, but no later than **180 days** after the accident or onset of sickness. Currently active participants are required to submit an application to the Fund Office in 60 days; this change is an improvement to the existing provision.

Special Participant Meeting

Additionally, a special meeting to discuss these changes has been scheduled at 10:00 am on Saturday May 11, 2019 located at the BAC Local 2 Union Office, 21031 Ryan Road, Warren, MI 48091.

With careful consideration and after much review, the Board of Trustees feel these changes are necessary based on our current fiscal position and reserve level. It is with the highest importance that we strengthen our reserve level to preserve the future of our plan.

Be sure to watch your mail for your new BCBSM ID card. We look forward to continuing to provide you with quality healthcare benefits. If you have questions, please feel free to contact the Fund Office at **(248) 828-6000 or (800) 435-4080**.

Sincerely,

Detroit & Vicinity Trowel Trades Health & Welfare Fund
Board of Trustees

Active Self-Payment Rates	Current Rate	New Rate Effective with Eligibility Month 9/1/2019
Active*	$255.00 Maximum	$766.00 Maximum

***you can continue coverage for one month, by making a self-payment to the Fund equal to the hourly contribution rate multiplied by the monthly hours needed for that month not to exceed the self-payment maximum.**

Non-Medicare Self-Payment Rates	Current Rate	New Rate Effective with Eligibility Month 7/1/2019
Early Retiree	$330.00	$766.00
Permanent & Total Disability	$209.00	$766.00
Surviving Spouse	$330.00	$766.00

Medicare Self-Payment Rates for 2019	Medicare Advantage Option 2	Medicare Advantage Option 1***
Retiree**	$384.88	$472.13
Permanent & Total Disability**	$384.88	$472.13
Surviving Spouse**	$384.88	$472.13

****per person rates**

*****you may choose Medicare Advantage Option 1 for additional premium difference of $87.25**