



ROOFERS LOCAL 149 FRINGE BENEFIT FUNDS

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October 2007

IMPORTANT NOTICE REGARDING PLAN CHANGES FOR DETROIT PARTICIPANTS AND DEPENDENTS

The Trustees of the Roofers Local 149 Security Benefit Fund diligently work to protect your benefits in an era of ever increasing health care costs and economic conditions which effect the contributions received by the Fund. After review of the current Plan, the Trustees have determined that certain changes are necessary to protect the financial integrity of the Fund, as follows:

1. Plan Changes Effective November 1, 2007

◆ **Co-payments for prescription drugs will be as follows:**

For drugs filled at a retail pharmacy, for a 34-day supply the co-payment will be:

\$15 for Generic drugs (increased from \$10)

\$30.00 for Brand Name drugs (increased from \$20) (please remember that if you receive a Brand Name Drug for a drug that has a Generic equivalent, in addition to the \$30, you must also pay the difference in the cost between the Brand Name and Generic drug)

For drugs filled via mail order for a 90-day supply, the co-payment will be:

\$30.00 for Generic drugs (increased from \$20)

\$75 for Brand Name drugs (increased from \$40) (please remember that if you receive a Brand Name Drug for a drug that has a Generic equivalent, in addition to the \$75, you must also pay the difference in the cost between the Brand Name and Generic drug)

◆ **Lasik Surgery/Dependent Child Pregnancy**

Effective November 1, 2007, Lasik Surgery and Dependent Child Pregnancy will no longer be covered benefits (coverage for pregnancies of participants and spouses will still be covered).



2. **Plan Changes Effective January 1, 2008**

Effective January 1, 2008, the following plan changes will be made:

◆ **Prescription Drug Coverage for Proton Pump Inhibitors**

Proton Pump Inhibitors (PPIs) are drugs commonly prescribed to treat conditions such as heartburn. As of January 1, 2008, these medications will only be covered under the Plan as follows: Subject to a \$15 co-payment, the Plan will pay \$50 per prescription, whether the prescription is filled through a retail or mail order pharmacy. The remainder of the cost of the drug is your responsibility.

There are several over the counter PPIs. Subject to a \$15 co-payment, with a physician prescription, the following over the counter PPIs will be covered:

Prilosec OTC and generic equivalents
Pepcid AC and generic equivalents
Pepcid Complete
Zantac and generic equivalents

◆ **Medical Plan Co-Insurance, Co-Payments, and Deductibles**

As you are aware, you are responsible for amounts known as co-insurance, co-payments, and deductibles. Attached please find a Chart of Benefits which will be effective January 1, 2008, which sets forth the co-insurance, co-payments, and deductibles for particular benefits. We would like to highlight the following changes:

Annual Deductible: This is the amount that you must pay out of pocket before any benefits will be paid by the Plan. These amounts are currently \$250 One Person, \$500 Two Person, or \$750 Three or more Covered Persons (Family) per Calendar Year. All benefits are subject to the deductible, unless otherwise stated in the Chart of Benefits. Although the amount of the deductible will not be changed, there have been some changes regarding which benefits are subject to the deductible. Please refer to the attached Chart of Benefits for details.

Co-payment: This is the flat dollar amount you must pay each time a particular service is received. Co-payments for several services have been increased from \$10 to \$15. Please refer to the attached Chart of Benefits for details.

Co-insurance: This is the percentage of the cost of a service you must pay. The Chart of Benefits indicates the percentage of a covered expense paid by the Fund. If the percentage is less than 100%, you are responsible for the remainder. For instance, for in-patient in-network surgery, the Fund will pay 90%. This means that you are responsible for paying the remaining 10%.

Prior to January 1, 2008, a number of benefits were covered at 100% in-network and 80% out-of-network. Effective January 1, 2008, these benefits will be covered at 90% in-network and 70% out-of-network. Please note, however, that the annual out of pocket maximum for co-insurance (in network and out of network claims combined) will be reduced to \$500 per Covered Person and \$1,000 per family per Calendar Year.

(The out of pocket maximum was previously \$1000 per covered Person and \$2,000 per family. Please note, the out of pocket maximum does not include co-payments or deductibles, or any benefits not subject to the co-insurance maximum as noted in the Chart of Benefits.)

Emergency Room Visits: Will be paid at 90%, after \$50 co-payment (decreased from \$75). The co-insurance, but not the co-payment, will be waived if you are admitted as a bed patient, or the purpose of the emergency room visit is to treat an Injury resulting from an Accident that occurred no more than 24 hours prior to the emergency room visit. (Previously, both the co-insurance and co-payment were waived if these conditions were met.)

Outpatient Surgery: This will be covered at 100% with no co-payment, but is subject to the annual deductible. (This was previously covered at 100%, after \$10 co-payment, and was not subject to deductible).

Urgent Care: This will be covered at 100%, after a \$25.00 co-payment, not subject to deductible. (This benefit was previously subject to the deductible.)

◆ **Self-Payments for Pensioners**

Effective January 1, 2008, self-payments for Pensioners shall be as follows:

P-1 rate: \$150.00 per month (increased \$25)

P-2 monthly rates increased \$50 as follows:

| | |
|--|----------|
| One Person with Medicare | \$262.50 |
| One Person with Medicare with Dependents | \$362.50 |
| Two Persons with Medicare | \$350.00 |
| One Person without Medicare | \$362.50 |
| One Person without Medicare with Dependents | \$462.50 |
| Two Persons without Medicare with or without Dependents | \$550.00 |
| One Person with Medicare with One Person without Medicare and Dependents | \$550.00 |
| One Person with Medicare with One Person without Medicare | \$450.00 |

If you have any questions regarding these changes, please contact the Benefit Office at (248) 641-4949 or toll free at (888) 868-6411.

Respectfully submitted,

**BOARD OF TRUSTEES
ROOFERS LOCAL 149
SECURITY BENEFIT TRUST FUND**

**ROOFERS LOCAL 149 SECURITY BENEFIT TRUST FUND – DETROIT GROUP
CHART OF REVISED BENEFITS EFFECTIVE JANUARY 1, 2008**

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| <u>INPATIENT</u> (a person is “inpatient” when he/she has spent over 23 consecutive hours in a Hospital) | | |
| Inpatient/Hospital Room and Board Limited to ward or semi-private rooms. | 90% | 70% of R&C, after \$75 co-payment |
| Surgery and Anesthesia (in hospital) | 90% | 70% of R&C |
| Technical Surgical Assistant Provided only where the complexity of the surgery warrants a surgical assistant | 20% of the surgical procedure allowance at 100% | 20% of the R&C surgical procedure allowance at 100% |
| Special care units (e.g. burn, cardiac, intensive care) | 90% | 70% of R&C |
| Physician Visits in Hospital | 90% | 70% of R&C |
| Physical Therapy | 90% | 70% of R&C |
| Diagnostic Lab, testing, and X-ray | 90% | 70% of R&C |
| Organ Transplants | 90% | 70% of R&C |
| Hemodialysis | 90% | 70% of R&C |
| <u>MATERNITY</u> | | |
| Eligibility: Maternity benefits are only available as follows: 1. For Spouses of Active Employees 2.. For Surviving Spouses of Active Employees for 9 months following death of such Active Employee | | |
| Office Visits Includes pre-natal office visits, post-natal office visits, related laboratory/diagnostic testing, etc. in conjunction with a maternity course | 90%, after \$15 co-payment on first visit only. Not subject to deductible. | 70% of R&C |
| In-Patient Hospital See Special Notice following this chart | 90% | 70% of R&C, with \$75 co-payment upon admission If the mother has a cesarean section and her son has a circumcision during the same in-patient stay, then only one \$75 co-payment will be charged |
| In-Patient Birthing Center See Special Notice following this chart | 90% | 70% of R&C, with \$75 co-payment upon admission If the mother has a cesarean section and her son has a circumcision during the same in-patient stay, then only one \$75 co-payment will be charged |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|--|
| Nurse-Midwifery Limited to care from a nurse-midwife who is a licensed registered nurse, has successfully completed formal advanced specialty training as a nurse-midwife in a program accredited by the American College of Nurse-Midwives; and is certified by the American College of Nurse-Midwives. The nurse-midwifery benefit will be paid for normal care surrounding the birth of a child. Services also include a week of visits with the mother. The American College of Nurse-Midwives must confirm that an individual is certified by that organization. | 90% | 70% of R&C |
| Routine In-Patient Well Newborn Care Limited to well newborn care services rendered during the first 7 days after birth while the newborn is Hospital confined. | 90% | 70% of R&C (if mother admitted, no additional deductible charged for newborn) Initial examination of newborn performed by Physician other than delivering Physician limited to \$120 |
| <u>OUTPATIENT</u> | | |
| Physician Visits (Office visit) | \$15 co-payment, then 100%. Not subject to deductible. | 70% of R & C, after \$15 copayment |
| Physical Exam for Active Employees, Pensioners, Spouses, and Surviving Spouses | 100%, limited to maximum benefit of \$300 per year. Not subject to deductible. | 80% of R & C after \$10 copayment, only if participant does not reside in Michigan, up to \$300 per year. No benefit for Michigan residents. |
| Well Baby Care for Children up to age 2 | 100%, less \$15 co-payment. Not subject to deductible. | No benefit; in-network benefit only |
| Urgent Care Facility | 100%, after \$25 co-payment. Not subject to deductible. | 70% of R & C, after \$25 co-payment |
| Emergency Room Visits | 90%, after \$50 co-payment The co-insurance requirement is waived if (1) the Covered Person is admitted as a bed patient, or (2) the purpose of the emergency room visit is to treat an Injury resulting from an Accident that occurred no more than 24 hours prior to the emergency room visit. | 70% of R&C, after \$50 co-payment The co-insurance requirement is waived if (1) the Covered Person is admitted as a bed patient, or (2) the purpose of the emergency room visit is to treat an Injury resulting from an Accident that occurred no more than 24 hours prior to the emergency room visit. |
| Immunizations for Children up to age 19 | 90%, not subject to deductible | No benefit – In-network benefit only |
| Diagnostic X-ray, Lab & Supplies in Doctor's Office or Outside Facility | 90%, after \$15 co-payment per billing statement, not subject to deductible | 70% of R&C |

| BENEFIT | IN-NETWORK PROVIDER | OUT-OF-NETWORK |
|--|--|--|
| Surgery/Anesthesia: Physician's Office or surgical facility | 100%, benefit subject to deductible | 70% of R&C |
| Assistant Surgeon | 20% of the surgical procedure allowance at 100% | 20% of the R&C surgical procedure allowance at 100% |
| Second Surgical Opinion | 90% | 70% of R&C |
| Speech Therapy | 90%, after \$15 co-payment, not subject to deductible | 70% R&C |
| Physical Therapy | 90%, after \$15 co-payment, not subject to deductible | 70% R&C |
| Hemodialysis Must be approved program of hemodialysis in an approved outpatient facility or home. Reasonable and necessary expenses for installation, maintenance and repair of equipment and supplies used in the home are covered. Includes related physician services when covered person is receiving treatment in approved facility. | 100%, limited to 120 days per Calendar Year – Fund will pay pursuant to Medicare Secondary Payer Rules | 80% R&C, limited to 120 days per Calendar Year– Fund will pay pursuant to Medicare Secondary Payer Rules |
| OTHER PROVISIONS | | |
| Psychiatric And Substance Abuse Treatment | 80% coverage, limited to 30 outpatient visits and 15 in-patient days. Maximum co-insurance limitation does not apply. | 80% coverage of R&C, limited to 30 outpatient visits and 15 in-patient days. Maximum co-insurance limitation does not apply. |
| Allergy Injections | 90%, after \$15 co-payment, not subject to deductible | 70% R&C |
| Diabetic Teaching Class | Cost of class covered at 100%, limited to maximum benefit of \$400.00. Covers one class only per Participant or Dependent per lifetime. Not subject to deductible. | Cost of class covered at 100%, limited to maximum benefit of \$400.00. Covers one class only per Participant or Dependent per lifetime. Not subject to deductible. |
| Radiation and Chemotherapy | 90% | 70% R&C |
| Durable Medical Equipment (equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury, and (d) is appropriate for use in the home) | 90% | 70% of R & C |
| Ambulance | 90%, after \$50 co-payment per trip; paid at 100% if admitted as bed patient | 70% of R&C, after \$50 co-payment per trip; paid at 80% if admitted as bed patient |
| Home Health Care | 90% | 70% |
| Hospice Care | 90%, up to \$90 per day, 90 day combined in-patient and out-patient limit | 70%, up to \$80 per day, 80 day combined in-patient and out-patient limit |
| Family Counseling | 80%, after \$50 co-payment and \$500 maximum benefit. Maximum co-insurance limitation does not apply. | 80%, after \$50 co-payment and \$500 maximum benefit. Maximum co-insurance limitation does not apply. |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|--|---|---|
| Family Bereavement Counseling | 80%, after \$50 co-payment, with maximum benefit of \$250 for maximum of 90 days. Maximum co-insurance limitation does not apply. | 80%, after \$50 co-payment, with maximum benefit of \$250 for maximum of 80 days. Maximum co-insurance limitation does not apply. |
| Skilled Nursing Facility | 90% | 70% |
| Chiropractic Services and Alternate Therapies - chiropractic, acupuncture, acupressure, therapeutic massage, biofeedback and homeopathy therapy provided by a practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license | 90%, after \$15 co-payment, limited to \$1,000 per year (including x-rays and related physical therapy) | 70%, after \$15 co-payment, limited to \$1,000 per year (including x-rays and related physical therapy) |
| TMJ/Jaw Joint | 90% | 70% R&C |
| Hearing Aids Replacement limited to once every 2 years. | 80%, up to \$1000. | 80% R&C, up to \$1000. |
| Mammograms Limit 1 every 6 months | 90%, not subject to deductible | 70% R&C |
| Sterilization (no reversal) | 100%, up to \$300.00 maximum benefit (one-time only). Deductible does not apply. | 100% R&C, up to \$300.00 maximum benefit (one-time only). Deductible does not apply. |
| Dental Surgery Surgery for multiple extractions or removal of unerupted teeth under general anesthesia where a concurrent hazardous medical condition exists, or surgery necessitated by an accident that occurred while eligible for coverage. | 90% | 70% of R & C |