MICHIGAN STATE PAINTERS INSURANCE FUND

November 2018

IMPORTANT NOTICE

TO: ALL ACTIVE AND RETIREE PARTICIPANTS

RE: SUMMARY OF MATERIAL MODIFICATIONS – EFFECTIVE JANUARY 1, 2019

Dear Participant:

The Board of Trustees of the Michigan State Painters Insurance Fund is continuously working to provide you and your family with the best benefits possible. However, in addition to the rising costs of health care, the Fund is subject to requirements under federal law. Accordingly, to preserve the financial stability of the Fund and its ability to continue coverage, the Board of Trustees has adopted several changes to the Plan and Summary Plan Description (the "Plan") in consultation with professional advisors. This notice explains these changes. Please read this notice carefully and keep it with your Plan for future reference. All changes are **effective January 1, 2019.**

DEDUCTIBLES

The Plan currently has an annual deductible of $250 per person and $500 per family for in-network services.

Effective January 1, 2019, the annual deductible for all in-network services will be of $500 per person and $1,000 per family.

COINSURANCE MAXIMUMS

The Plan currently has a coinsurance maximum of $1,500 per person and $3,000 per family for in-network services.

Effective January 1, 2019, the coinsurance maximum will be $2,500 per person and $5,000 per family.

OFFICE VISIT and CHIROPRACTIC VISIT CO-PAYMENTS

The Plan currently has an office visit co-payment of $20 per visit with no co-payment for a chiropractic visit.

Effective January 1, 2019, office visit and chiropractic visit co-payments will be $30 per visit.

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EMERGENCY ROOM CO-PAYMENTS

The Plan currently has an emergency room co-payment of $50 per visit.

Effective January 1, 2019, the emergency room co-payment will be $200 per visit for Actives and Early Retirees. The emergency room co-payment will be $120 per visit if you are retired and eligible for Medicare.

PRESCRIPTION DRUG CO-PAYMENT

The Plan currently has a $15 co-payment for generic drugs, a $30 co-payment for brand name drugs, and a $30 co-payment for a 31 to 90 day supply of mail order prescription drugs.

Effective January 1, 2019, prescription coverage will change to a five tier program. Generic drug co-payments will be **$15**, preferred brand name drug co-payments will be **$30**, non-preferred brand name drug co-payments will be **$60**, generic and preferred brand name specialty drug co-payments will be 20% up to a maximum co-payment of $200, and non-preferred brand name specialty drug co-payments will be 25% up to a maximum co-payment of $300.

Along with the change in prescription co-payments, the Trustees are also implementing the following changes:

Medical Specialty Drugs

Effective January 1, 2019, the Plan will require prior authorization for select specialty pharmaceutical drugs administered in Blue Cross Blue Shield of Michigan ("BCBSM")-approved locations, such as a doctor's office, clinic, or home drug administration.

Under the current Plan, prior authorization is not required and the cost of specialty drugs are covered subject to your deductible and coinsurance obligations. Effective January 1, 2019, your physician must contact BCBSM to obtain prior authorization for coverage of certain specialty drugs. 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 coinsurance.

Please call the **Clinical Help Desk** at **1-800-437-3803** to inquire about what drugs are considered medical specialty drugs.

Pharmacy Initiatives

Effective January 1, 2019, the Plan will institute BCBSM's pharmacy initiatives. These include dose optimization, brand to alternate generic interchange, one-time generic co-pay waiver, and quantity limits.

Under the dose optimization program, BCBSM may discuss with your doctor use of specific prescription drugs in once-daily dosage regimens as opposed to using lower, multiple doses of the same drug. Under the brand to alternate generic interchange, BCBSM may discuss with your doctor options to replace a single source brand name drug with an equally effective, less-costly generic alternative. Under the one-time generic co-pay waiver, the Plan will provide you with a one-time co-pay waiver if you switch from a targeted high-cost brand name drug to an equally effective, less-costly generic equivalent. Under the quantity limits program, BCBSM may limit the quantity of select drugs to maintain consistency with Federal Drug Administration dosing guidelines.

Prior Authorization and Step Therapy for Certain Prescription Drugs

Effective January 1, 2019, the Plan will institute prior authorization and 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 Plan's pharmacy benefits manager for prescriptions written by your doctor.
Under the new prior authorization program, the use of some prescription drugs will be reviewed by BCBSM before their use is authorized. If your doctor does not seek and obtain prior authorization when required, you may be responsible for the full cost of your prescription without regard for your deductible or coinsurance. Therefore, you should consult with your doctor about whether prior authorization is needed when receiving a new prescription.

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, you may be responsible for the full cost of your prescribed drug without regard for your deductible or coinsurance. Therefore, you should consult with your doctor about whether step therapy is needed when receiving a new prescription.

Please visit "bcbsm.com/pharmacy" for more information about prior authorization and step therapy.

TRUE OUT OF POCKET MAXIMUM, PREVENTATIVE SERVICES AND APPEALS

Because of Plan changes, the Plan will lose grandfathered status, which imposes certain requirements under law. First, the Plan must implement a True Out of Pocket Maximum ("TROOP"). TROOP is an additional maximum that would go into effect in the event that a participant reaches a threshold for all co-pays, coinsurance and in-network deductibles. The 2019 TROOP limit is $7,900 per person and $15,800 per family.

The Plan will also provide coverage for preventative services without any cost sharing requirements for in-network claims. Preventative services include annual routine physicals, immunizations and contraceptives.

The Fund's appeal process will change to include an internal appeal and external appeal process.

DENTAL BENEFIT MAXIMUM

The Plan's current dental benefit pays 80% for dental treatment up to a maximum of $1,500 per person, per calendar year, without deductibles.

Effective January 1, 2019, the benefit will change to 100% for diagnostic and preventive services, 80% for in-network basic services and 50% for out-network basic services and 50% for in and out-of-network major services, including orthodontics, for a maximum of $1,500 per person, per calendar year, without deductibles.

SUPPLEMENT TO MEDICARE COVERAGE

Under the Plan's current coverage, Medicare is primary and the Plan is secondary for Medicare-eligible participants under Medicare Supplemental Coverage.

Effective January 1, 2019, the Plan is changing the benefit program available to retirees and dependents who are eligible for Medicare. In place of your current traditional Medicare (Parts A and B) and the supplemental

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coverage available through the Plan's Medicare Supplemental Coverage, the Plan will provide benefits under a group Medicare Advantage Preferred Provider Program administered by BCBSM. This program, known as "Medicare Plus Blue Group PPO" ("MPBG-PPO"), provides substantially the same medical benefits you previously received through the Plan. Implementing the MPBG-PPO will not significantly change your benefits, even though your current Medicare Supplemental Coverage will be discontinued after December 31, 2018.

This change applies only to Medicare-eligible retirees and to a retiree's Medicare-eligible dependents (including the Medicare-eligible dependent of a retiree who is not eligible for Medicare and covered under the Plan's Early and Disabled Retiree Benefits). If you are not yet eligible for Medicare, your coverage will remain under the Plan's coverage for non-Medicare-eligible participants.

As described below, you will be automatically enrolled in the Medicare Plus Blue Group PPO program unless you decide not to participate.

Advantages of the Medicare Plus Blue Group PPO
Under BCBSM's MPBG-PPO, BCBSM will administer **both** your Medicare and Supplemental Medicare benefits. This means that:

- You will only have to carry ***one ID card.*** You may put your Medicare "red, white, and blue" card away for safekeeping and only use your new Blue Cross MPBG-PPO card.

- You will only receive ***one Explanation of Benefits (EOB)*** for each service rendered. You won't have to compare your Blue Cross and Medicare EOBs to understand how claims are paid.

- You will receive only ***one benefit book***. You will not have to go back and forth between your Plan and Medicare benefit books to determine which plan covers what benefits.

- You will have access to BCBSM's ***dedicated Medicare Advantage Member Service Center.*** While you will always be a Medicare beneficiary and have continued access to Medicare rights and privileges, your service needs can be handled by calling your BCBSM MPBG-PPO customer service representatives who have been specifically trained on Medicare and Medicare Advantage benefits, including MPBG-PPO benefits.

What you should know about your new Medicare Plus Blue Group-PPO coverage.

- ***Almost no change in benefits*** - The MPBG-PPO is designed so that its in-network benefits are substantially the same as your current Medicare supplemental benefits.
- ***Extensive Provider Access*** - **BCBSM's MPBG-PPO Provider Network** offers similar statewide and nationwide access to care that is available under the current Plan. Therefore, you can continue to receive services from all providers that accept Medicare assignments.

- The Plan has selected a "passive PPO." A passive PPO takes advantage of the provider network arrangements and medical management components of BCBSM's PPO network. Plan participants will receive medical benefits from any provider that accepts Original Medicare (in-network or out-of-network) both in-state and out-of-state, with the participant's cost share for in-network and out-of-network services

contributing to a single deductible limit and out-of-pocket maximum. Participants are liable for all deductibles and coinsurance until the out-of-pocket maximum is reached.

- **Network and Medical Management** – Your new MPBG-PPO includes programs designed to improve quality of care while containing costs through the use of networks. In addition to MPBG-PPO's physician and hospital networks, MPBG-PPO also uses networks to help control the costs of retail and mail order pharmacy, laboratory, diagnostics, durable medical, prosthetics/orthotics/medical supplies and hi-tech imaging services.

  The member materials and welcome kit that you will receive when it is time for you to enroll in BCBSM's MPBG-PPO will include provider directories so that you can see whether your doctors are in the MPBG-PPO network. However, the easiest way to find out if your doctor participates in the MPBG-PPO is to call and ask your doctor's office directly. You can also visit the BCBSM website at www.bcbsm.com.

Enrolling in the new plan

You will receive a pre-enrollment package from BCBSM. It will include a Summary of Benefits, an opt-out form (coverage waiver), and other information about the MPBG-PPO Medicare Advantage program.

You will automatically be enrolled in the Medicare Plus Blue Group PPO plan unless you decide not to participate and complete and return the waiver form. You will only have to complete forms if you do not want to participate in MPBG-PPO**.**

Participation in MPBG-PPO is a condition for coverage under the Plan for all Medicare-eligible participants. ***IF YOU CHOOSE NOT TO PARTICIPATE IN MPBG-PPO, YOU WILL NOT BE ELIGIBLE FOR ANY OTHER PLAN COVERAGE. However, if you are Medicare-eligible and waive (opt out of) Plan coverage, you may opt back into coverage so long as you provide proof that you had continuous health care coverage during your opt-out period and otherwise satisfy the Plan's eligibility requirements.***

SELF-PAYMENT RATES

The current self-payment rates that apply to Plan participants will continue in effect unless they are changed by the Fund's Board of Trustees. The Trustees regularly review self-payment rates.

For Medicare-eligible participants, be sure to watch your mail for your Medicare Plus Blue Group PPO materials.

We look forward to continuing to provide you with quality health care benefits in the upcoming year. If you have questions, please feel free to contact the Fund Office.

Sincerely,

Board of Trustees
Michigan State Painters Insurance Fund