MICHIGAN BAC FRINGE BENEFIT FUNDS

Michigan BAC Health Care Fund
Michigan BAC Pension Fund
Michigan BAC Apprenticeship Fund

Managed for the Trustees by:
TIC INTERNATIONAL CORPORATION

October 2016

TO: **ALL ACTIVE AND PRE-MEDICARE RETIRED PARTICIPANTS OF THE MICHIGAN BAC HEALTH CARE FUND**

RE: **SUMMARY OF MATERIAL MODIFICATIONS TO FUND BENEFITS**

- **Deductibles**
- **Co-Insurance**
- **Co-Payments**
- **Pre-Authorization/Step-Therapy**
- **Medical Specialty Drugs**
- **Skilled Nursing Facility Services**
- **Post-Natal Care**
- **Physical/Occupational/Speech Therapy**

Dear Participant:

This is a Summary of the Material Modifications (SMM) we've made to your Fund Benefits. All of the benefit changes identified and explained below are ***effective January 1, 2017***.

1. DEDUCTIBLES

Deductibles are amounts you pay for covered services ***before*** the Plan starts paying. Deductibles are calculated on a calendar-year basis.

A. Current Deductibles

$200 per person
$400 per family

Currently, you pay these annual deductibles whether your services are in-network or out-of-network.

B. New Deductibles

Effective January 1, 2017, your deductibles will increase as set forth below. And, the deductibles for in-network and out-of-network services will increase at different rates.

- ***In-Network Deductibles***

  $250 per person
  $500 per family

- ***Out-of-Network Deductibles***

  $500 per person
  $1,000 per family

The in-network and out-of-network deductibles are, for the most part, calculated separately. This means that any payments you make for your annual *in-network* deductible won't apply to your annual *out-of-network* deductible.

On the other hand, payments you make for your annual *out-of-network* deductible are applicable to your annual *in-network* deductible.

> ***For example***: On March 1, 2017, you meet your $250 *in-network* deductible for the year. If you then use *out-of-network* services during that year (2017), your *out-of-network* deductible is still $500.
>
> ***But,*** any amounts you pay for your *out-of-network* deductible during the year (2017) will apply to your *in-network* deductible for 2017.

2. CO-INSURANCE

Co-insurance is your share of the costs for covered services ***after*** your deductible is met.

A. Current Co-Insurance

10% of covered services with $1,000 family cap.

B. New Co-Insurance

Effective January 1, 2017, your co-insurance will increase as set forth below. The co-insurance for in-network and out-of-network services will increase at different rates.

20% of in-network covered services with $1,000 family cap.

40% of out-of-network covered services with $2,000 family cap.

3. CO-PAYMENTS

Co-payments are fixed dollar amounts you pay for covered health care, usually at the time of service. ***Effective January 1, 2017,*** the current co-payments are changing as set forth in the following chart:

Service	**Current Co-payment**	**Co-payment effective January 1, 2017**
Office visit	$20	$40
Chiropractic visit	$20 (limited to 38 visits per year)	$40 (limited to 24 visits per year)
Urgent Care visit	$20	$40
Emergency Room visit	10% co-insurance based on BCBSM-approved amount	$250 per visit (waived if you're admitted to the hospital)
Prescription Co-payments (30 day supply)	Generic: $10 Preferred: $20 Non-preferred: $30	Generic: $20 Preferred: $40 Non-preferred: $60
Prescription Co-payments (90 day supply)	Two times (2x) the thirty day supply co-payment amount -- paid at participating Retail Pharmacies	Two times (2x) the thirty day supply co-payment amount -- paid at participating Retail Pharmacies or BCBSM Mail Order Program.

4. PRIOR-AUTHORIZATION AND STEP THERAPY

Effective January 1, 2017, prior-authorization and/or step therapy is required before you fill your initial prescription for select high-cost, brand-named drugs -- whether the drugs are dispensed by a retail pharmacy or through mail order.

Your pharmacy will contact your doctor regarding a generic alternative. But, if BCBSM's records confirm that, within the last 180 days, you've already tried a generic equivalent for the brand-name drug, your prescription will be authorized and no further action is required. If there's no record that you tried the recommended generic drug, you may be liable for the entire cost of the brand-name drug.

5. MEDICAL SPECIALTY DRUGS

Prior authorization is required for select, specialty pharmaceutical drugs administered in BCBSM-approved locations. This includes office, clinic, or home drug administration.

Your physician must contact BCBSM to obtain preauthorization. If preauthorization is not requested and approved by BCBSM, you may be responsible for the full cost of the specialty drug.

6. SKILLED NURSING FACILITY SERVICES

Currently, there are no benefits for skilled nursing facility services.

Effective January 1, 2017, facility and professional services are covered in a **BCBSM participating** skilled nursing facility for up to 120 days each calendar year. The admission must be ordered by the patient's attending physician.

7. POST-NATAL CARE SERVICE

Currently, these benefits involve a 10% co-insurance charge.

Effective January 1, 2017, post-natal care services are covered at 100% of the BCBSM-approved amount -- that is, deductibles, co-insurance and co-payment charges do not apply to *in-network* post-natal care services.

8. PHYSICAL/OCCUPATIONAL/SPEECH THERAPY

Currently, there is no limit on the number of visits for these services.

Effective January 1, 2017, services for physical, occupational, and speech therapy are limited to 60 visits each calendar year.

WHY HAVE WE MADE THESE CHANGES?

We've made these changes only after considerable review. These changes are a necessary and prudent way to manage your benefit program. We understand the disruption caused by these changes. But, these changes are unavoidable.

Sincerely,

Michigan BAC Health Care Fund
Board of Trustees

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