Michigan Laborers’ Fringe Benefit Funds

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December, 2009

TO: ALL PARTICIPANTS OF THE MICHIGAN LABORERS’ HEALTH CARE FUND

RE: SUMMARY OF MATERIAL MODIFICATIONS FOR:
Office Visit Co-Payments
Chiropractic Visit Co-Payments
Prescription Drugs
Dental, Vision and Hearing Benefits

Dear Participant:

As you know, we carefully and routinely review the Fund benefits, the Fund’s finances, and health care cost increases. As a direct result of the dramatic slowdown in work, the hourly contributions to the Fund have dropped significantly. This has occurred, unfortunately, while medical costs are increasing at an alarming rate.

These dramatic events force us to take dramatic action to protect your Fund and benefits. Below, we explain the necessary and unavoidable changes we must make in Fund benefits. We know that these benefit changes, while required, are difficult and painful. Be assured, we made these changes only after a long and thoughtful review. They are our best judgment as how to best respond to a nearly impossible problem – a dramatic drop in employment and Fund revenue and the ever-increasing costs of healthcare coverage.

These changes, ALL OF WHICH BECOME EFFECTIVE JANUARY 1, 2010, are as follows:

1. **Office Visit Co-Payments**

   a. **In-Network**

   The Fund currently requires an office visit co-payment of twenty percent (20%) of the BCBSM approved amount per visit for in-network office visits. This current office visit co-payment will change to a flat twenty dollars ($20.00) for each in-network office visit.
Please note: This twenty dollar ($20.00) co-payment for in-network office visits does not apply against your maximum, per calendar year co-payment amount of one thousand, two hundred dollars ($1,200.00). In other words, your one thousand, two hundred dollars ($1,200.00) per calendar year co-payment maximum is not reduced by your payment of this new twenty dollar ($20.00) co-payment.

b. Out-of-Network

The Fund currently requires a total co-payment amount of thirty percent (30%) for all out-of-network office visits. This current office visit co-payment will now also include twenty dollars ($20.00) for each out-of-network office visit. So, effective January 1, 2010, each out-of-network office visit will require a twenty dollar ($20.00) co-payment plus an additional thirty percent (30%) co-payment.

The twenty dollar ($20.00) charge for each out-of-network office visit will also not apply against your maximum, per calendar year co-payment of one thousand, two hundred dollars ($1,200.00) for in-network co-payments or the additional one thousand ($1,000.00) for out-of-network copayments.

2. Chiropractic Spinal Manipulation

The Plan currently provides for one hundred percent (100%) coverage of in-network chiropractic spinal manipulation up to seven hundred dollars ($700.00) per calendar year. Effective January 1, 2010, a co-payment of twenty dollars ($20.00) per chiropractic spinal manipulation or office call is required.

For out-of-network services, you must also pay the co-payment of twenty dollars ($20.00) per chiropractic spinal manipulation or office call plus an additional thirty percent (30%) copayment.

3. Prescription Drug Coverage

The Fund currently provides for a prescription drug co-payment of twenty dollars ($20.00) for all generic prescription drugs and forty dollar ($40.00) for all brand name prescription drugs. These co-payments will change to ten dollars ($10.00) for generic prescription drugs, forty dollars ($40) for “formulary” brand drugs and sixty dollars ($60.00) for “non-formulary” brand drugs.

Your prescription drug benefit will now follow the Blue Cross Blue Shield of Michigan (BCBSM) Custom Formulary. A formulary is simply a regularly-updated list of Federal Drug Administration (FDA)-approved drugs.
The Formulary, which favors and encourages the use of generic drugs, is divided into three (3) tiers:

Tier 1 – generic drugs
Tier 2 – Formulary brand drugs
Tier 3 – Non-Formulary brand drugs

This use of the Formulary impacts the amount of your co-payment. Generally, your co-payment amount is lowest (**$10.00**) for generic drugs (Tier 1 – Generic), higher (**$40.00**) for preferred brand-name drugs (Tier 2 – Formulary brand), and highest (**$60.00**) for Non-Formulary brand name drugs (Tier 3 – Non-Formulary).

A Quick Reference Guide is enclosed for your review of the most commonly prescribed drugs under the new Formulary program. For a complete list of drugs included in BCBSM’s Custom Formulary, or to look up your own specific drug(s) to see what tier (Tier 1, Tier 2 or Tier 3 as indicated above) they are in, visit:

http://www.bcbsm.com/member/prescription_drugs/formulary_lookup.shtml

To view the complete Custom Formulary list, click on the blue link at the top of the screen that says: “View the complete 2009 Custom Formulary (PDF)”. To view your own specific drug(s), enter the name of your drug in the box under the heading “Drug Name Search”.

4. **Dental, Hearing and Vision Benefits**

The Dental, Hearing and Vision Benefits are eliminated completely. Procedures such as orthodontics, root canals, dentures and crowns, may be reimbursed up to the Plan maximum **provided** the treatment was started **prior** to January 1, 2010. Documentation regarding the first treatment date is required.

If you have any questions regarding the above, please do not hesitate to contact the Fund Office.

Sincerely,

Michigan Laborers’ Health Care Fund
Board of Trustees