MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

July 2014

TO: ALL ELIGIBLE PARTICIPANTS OF THE MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN AND THEIR DEPENDENTS

RE: SUMMARY OF MATERIAL MODIFICATIONS –
Annual Dollar Limits
Out-of-Pocket Limits
Preexisting Condition Exclusions
Special Fund
Provider Non-Discrimination
Approved Clinical Trials
Smoking Cessation
Prenatal Care

Dear Participant:

This notice contains information about changes to your plan of benefits required by the Affordable Care Act. Please read this notice carefully and keep it with your Summary Plan Description (SPD) booklet for future reference.

Annual Dollar Limits
Effective September 1, 2013, the $5,000,000 annual dollar limit was removed.

Out-of-Pocket Limits
The Department of Health and Human Services has mandated implementation of additional protective out-of-pocket maximums for participants. Effective September 1, 2014 out-of-pocket expenses for deductibles, coinsurance and copayments for approved **medical and pharmacy** services will count towards new maximums and an annual cap on copayments will apply for the first time.

Your current deductible ($500/person or $1,000/family) and coinsurance (20% to a maximum of $2,000/person or $4,000/family) for medical services **does not change**. Once you or your family satisfy these, no additional deductible or coinsurance obligation applies for the remainder of the calendar year. You and your family remain responsible for paying copayments for office visits, chiropractic services, etc. and copayments for pharmacy services. There currently are no limits on the amount of copayments that you and your family must pay. However, under the new mandated maximums, deductibles, coinsurance payments and copayments for your **medical and pharmacy** services will now be combined and applied towards a new overall out-of-pocket maximum of $6,350/person or $12,700/family. If a participant has out-of-pocket expenses that exceed these new levels, the plan will pay 100% of approved **medical and pharmacy services** for the remainder of the calendar year. Both PPO and approved non-PPO expenses will continue to apply to the out-of-pocket maximums.

Assume for the following examples that you have self-only coverage:

- Once you pay the $500 deductible and $2,000 in coinsurance in a calendar year, the Plan will pay 100% of approved medical services that are subject to coinsurance for the remainder of the calendar year. You will continue paying copayments for office visits, chiropractic services and pharmacy services like you have in previous years. However, now if, in that same calendar year, you pay $3,850 in copayments (for a total of $6,350 in out-of-pocket expenses), the Plan will pay 100% of all approved medical and pharmacy services for the remainder of the calendar year.
- Assume instead that you have many office visits and pharmacy services in a calendar year and pay $4,000 in copayments. In that same calendar year, once you pay the $500 deductible and $1,850 in coinsurance (for a total of $6,350 in out-of-pocket expenses), the Plan will pay 100% of all approved medical and pharmacy services for the remainder of the calendar year.

The new, protective out-of-pocket maximums will be increased each calendar year by the premium adjustment percentage specified by the Department of Health and Human Services. For calendar year 2015, the new maximums are $6,600/person or $13,200/family. Note that out-of-pocket expenses for the following do not count toward meeting any out-of-pocket maximums:

- Charges by out-of-network providers that are in excess of the BCBSM approved amounts.
- Expenses not considered covered medical expenses.
- Expenses incurred after any maximum benefit limit or other limitation has been reached for specified services.
- Expenses for the difference in cost between the generic drug cost and the brand name drug cost when a generic equivalent is available.

Preexisting Condition Exclusions

Effective September 1, 2014, the Plan's preexisting condition exclusion is eliminated for all individuals.

Special Fund

Effective September 1, 2014, the following new rules will apply to the Special Fund:

- Opt-out of Account. You will be given the opportunity to opt-out of the Special Fund and waive all future reimbursement from your Special Fund account annually. Additionally, you will be given an opportunity to opt-out of the Special Fund when you lose eligibility for Health Plan coverage and when you retire. Your Dependents will be given an opt-out opportunity upon your death.
- Forfeiture of Account. If you, or your Dependents, elect to opt-out of the Special Fund, all amounts recorded in your account will be forfeited back to the Health Plan and will not be reinstated if you subsequently choose to reenroll in the Special Fund.
- Special Fund Covered Expenses. Health care coverage insurance premiums are no longer eligible medical expenses for active employees. However, after you retire, amounts you and/or your spouse pay for other health coverage (such as employer insurance, individual

policy insurance, or Medicare, provided it is not paid or eligible for payment on a pre-tax basis) and, after your death, amounts your surviving Dependents pay for such other health coverage are covered expenses.

Provider Non-Discrimination

Effective September 1, 2014, the Plan will not discriminate based on the license or certification of the individual providing the service, if the individual is properly licensed and acting within the scope of their license. Accordingly, to the extent required by the Affordable Care Act and available guidance, if a service is covered under the Plan, the Plan will not discriminate based on the license or certification of the individual providing the service, if the individual is licensed to provide such services in the state in which the services are performed and the individual is acting within the scope of that license.

Approved Clinical Trials

Effective September 1, 2014, the Plan will not deny any qualified individual the right to participate in an approved clinical trial; deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the approved clinical trial; and will not discriminate against any qualified individual who participates in an approved clinical trial. Qualified individuals must use a PPO Provider if a PPO Provider is participating in an approved clinical trial and the PPO Provider will accept the qualified individual as a participant in the approved clinical trial.

A qualified individual is a covered person who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening condition and either (a) the referring health care professional is a participating provider and has concluded that the Participant's participation in the approved clinical trial would be appropriate or (b) the covered person provides medical and scientific information establishing that participation in the approved clinical trial would be appropriate.

Routine patient costs are items and services typically provided under the Plan for a covered person not enrolled in an approved clinical trial. However, such items and services do not include (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

An approved clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition and is:

- Approved or funded by an approved agency or entity (contact the Plan Office for a listing of approved agencies and entities)
- Conducted under an investigational new drug application reviewed by the FDA, or
- A drug trial that is exempt from having such an investigational new drug application.

A life-threatening condition is a disease or condition likely to result in death unless the disease or condition is interrupted.

Smoking Cessation Benefits

The Plan covers smoking cessation benefits to the extent required under the Affordable Care Act's preventive care rules. Effective September 1, 2014, the Plan is expanding its preventive care coverage of smoking cessation benefits. Each year under the Plan's preventive care benefit, you may be eligible for a tobacco use screening, four tobacco cessation counseling sessions of 10 minutes each and the following smoking cessation drugs, including over-the-counter drugs, with a prescription:

- Nicotine gum
- Nicotine lozenge
- Nicotine patch
- Bupropion (generic Zyban)
- Chantix
- Nitcotrol, Nicotrol NS

Quantity limits and prior approval from BCBSM may apply.

Prenatal Care

Effective September 1, 2014, the Plan is expanding the coverage offered for prenatal care under the preventive care benefit. The Plan will now cover all prenatal care expenses provided by a PPO Provider at 100%, not subject to the deductible.

If you have any questions regarding the changes described above, please do not hesitate to contact the Plan Office at 1-855-633-4584.

Sincerely,

Michigan Electrical Employees' Health Plan
Board of Trustees

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Please note that receipt of this description of benefit modifications is not a guarantee of coverage. You will only be eligible for the benefits described herein if contributions are required to be made to the Fund on your behalf. The Trustees reserve the right to amend, modify or terminate the Plan at any time.