OE3 Trust Funds
Health. Security. Service.

Operating Engineers Trust Funds
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Date **January, 2015**

To: **Participants and Dependents in the Pensioned Operating Engineers Health and Welfare Trust Fund**

This notice will advise you of material modifications made to the Trust Fund's benefit plan effective January 1, 2015. **This information is VERY IMPORTANT to you and your Dependents**. Please take the time to read it carefully.

Note: The changes in this notice apply to the Comprehensive Medical Plan only. They do not apply to participants enrolled in an HMO.

Medical Out-of-Pocket Limit (Annual Limit on Cost Sharing)

In compliance with Health Reform regulations, the Trustees made a change to the Out-of-Pocket Limit, which limits your total annual cost-sharing for covered essential health benefits. Effective January 1, 2015, ***the family Out-of-Pocket Limit for Contract Providers is reduced from $12,700 to $11,000 per family.***

All deductibles and copayments, as well as any coinsurance you pay, accumulate to the Out-of-Pocket Limits, which are shown below:

- **Contract Providers: $5,000 per person per calendar year, and $11,000 per family per calendar year**. These amounts may be adjusted annually in accordance with Health Reform regulations.

- **Non-Contract Providers: $10,000 per person per calendar year, no family limit.** These amounts may be adjusted by the Trustees.

The Out-of-Pocket Limit on cost sharing is accumulated on a calendar year basis. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Fund. Non-Contract emergency services performed in an emergency room will also apply to meet the Contract Provider Out-of-Pocket Limit.

Exceptions to Out-of-Pocket Limit. The Out-of-Pocket Limit does not accumulate premiums, balance-billed charges in excess of allowed charges, non-covered expenses, charges in excess of benefit maximums or amounts over the plan maximum amount for certain surgeries, a penalty for failure to obtain precertification, dental and vision plan expenses, prescription drug expenses (see new Prescription Drug Out-of-Pocket Limit described in the next section) or charges for certain treatment at a facility that is not a Center of Medical Excellence.

New Prescription Drug Out-of-Pocket Limit (Annual Limit on Cost Sharing)

Previously, there was no Out-of-Pocket Limit for outpatient prescription drugs. In compliance with Health Reform regulations, ***the Trustees have added a separate Out-of-Pocket Limit for outpatient prescription drugs effective January 1, 2015. This Out-of-Pocket Limit applies to OptumRx participating pharmacies only.***

Calendar Year Out-of-Pocket Limit on Prescription Drugs – Participating Pharmacies Only. Each calendar year, after you or your family incurs the maximum out of pocket cost shown below for covered prescription drugs, the Plan will pay 100% of covered expenses for the rest of that calendar year.

- **Out-of-Pocket Limit: $1,600 per person per calendar year, and $2,200 per family per calendar year**. These amounts may be adjusted annually in accordance with Health Reform regulations.

Copayments, coinsurance and deductibles (if any) that you pay for covered medications purchased from an OptumRx participating pharmacy (retail, mail order or Specialty pharmacy) are counted toward the Out-of-Pocket Limit.

Exceptions to Out-of-Pocket Limit. The following are not accumulated to the Out-of-Pocket Limit and are not covered at 100% after the limit is reached:

- Expenses for drugs purchased at a Non-Participating Pharmacy
- Charges in excess of the Plan benefit maximums for PPI drugs and compound drugs
- Non-covered expenses or balance-billed charges
- Premiums or self-pay contributions

Change in Specialty Drug Copays

The Trustees have made a change to the participant copays for ***Specialty Drugs effective January 1, 2015***. Please note that ***these new copays apply to Specialty Drugs only***; there is no change to the copays for other covered drugs.

The following Copays will apply to Specialty Drugs obtained from the OptumRx Specialty Pharmacy and each prescription is limited to a 34-day supply.

- Specialty Generic Formulary: You pay 20% of cost, up to a $50 maximum Copay
- Specialty Brand Preferred: You pay 20% of cost, up to a $100 maximum Copay
- Specialty Non-Preferred: You pay 20% of cost, up to a $200 maximum Copay

Grandfathering Exception for Specialty Drugs Taken During the Period October 1, 2014 Through December 31, 2014. If you used a Specialty Drug during the period October 1, 2014 through December 31, 2014, you will be grandfathered for that drug at the retail pharmacy copayments instead of the new Specialty Drug copayments shown above***. This exception will not apply to any new Specialty Drugs prescribed on and after January 1, 2015.***

As in the current plan, no benefits are payable for paper claims submitted for Specialty Drugs purchased from a pharmacy other than the OptumRx Specialty Pharmacy.

The one time exception for the first fill of a Specialty Drug at a non-OptumRx pharmacy is eliminated. Effective January 1,2015, **all** Specialty Drugs must now be purchased from the OptumRx Specialty Pharmacy in order to be covered by the Plan.

Change in Compound Drug Benefit

The Trustees have made a change to the Trust Fund's compound drug benefit. A **Compound Drug** is any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law. Some compound drugs are only available at a retail pharmacy location, not mail order. Pharmacy compounding is a practice in which a pharmacist combines, mixes, or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient.

Effective January 1, 2015, each Compound Drug prescription that is filled is subject to the brand name drug $35 copay.

Select non-FDA approved bulk chemicals used in compounds will no longer be covered effective January 1, 2015. See attached Compound Medication Exclusion List (which is a dynamic list and subject to change).

Compounded medications with a cost greater than $150 will be subject to review. Your pharmacist can initiate the process by calling the dedicated Operating Engineers help desk at 1-855-OPA-ENGI (1-855-672-3644).

Anthem Blue Cross LiveHealth Online Services

The Trustees have approved the implementation of the Anthem Blue Cross LiveHealth Online services effective January 1, 2015 at the cost of $15 copay (deductible waived).

Members can now use their smart phone, tablet or computer to have a live video visit with a board certified doctor affiliated with the Anthem Blue Cross LiveHealth Online Services to discuss non-emergency health issues from home, work or wherever they happen to be as long as they have Internet access. This new online care service, **LiveHealth Online**, offers a secure means of reaching board-certified, primary care doctors on demand, especially when plan participants find it inconvenient to leave work or home and go to a doctor's office. Online care, for non-urgent medical conditions, is more convenient and affordable than a visit to the emergency room or an urgent care clinic. Patients use online care typically to communicate with a doctor about colds, aches, sore throats, allergies, infections as well as wellness and nutrition advice.

We are attaching information from Anthem that outlines this new and exciting program.

(Please note that Medicare does not cover this LiveHealth Online service. Claims will be paid as primary by the Fund.)

Change in Foot Orthotic Benefit

Foot orthotics are currently limited to an annual maximum of $500.

Effective January 1, 2015, each pair of foot orthotics is limited to a maximum benefit of $500.

If you have any questions, please contact the Trust Fund Office at the numbers listed above. You may also call the Fringe Benefits office at (800) 532-2105.

Sincerely,
Board of Trustees

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Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, please contact the Trust Fund Office.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.