Automotive Industries Welfare Fund

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September 2012

To: **All Participants**

From: **Board of Trustees**

Subject: **Termination of Health Net Coverage and Benefit Changes Effective January 1, 2013**

This information is VERY IMPORTANT to you and your dependents.
Please take the time to read it carefully.

1. TERMINATION OF HEALTH NET COVERAGE

Plans A and B Participants

Each year, the Board of Trustees reviews the renewal terms proposed by the Health Maintenance Organizations (HMO's) that are available through the Fund. This year, the Board has determined it will not renew the contract with Health Net, as the proposed rate was not in line with the Fund's assets and projected performance. The contract will terminate on December 31, 2012. This will mean that you will no longer have the $50 surcharge previously required for selecting the Health Net option.

The Direct Pay Medical Plan and the Kaiser Permanente HMO plan will both continue to be offered as medical plan options through the Fund. If you are currently covered under the Health Net plan, you will automatically be defaulted into the Direct Pay Medical Plan unless you elect the Kaiser plan. If you want to enroll in Kaiser effective January 1, 2013, the Fund Office must receive your application by no later than December 14, 2012.

You are being defaulted into the Direct Pay Medical Plan for the following reasons:

- You may use any physician you want under the Direct Pay Plan and your current provider may be an Anthem Blue Cross PPO provider. Be sure to check (www.anthem.com).

- Plan A Direct Pay coverage provides you with Health Reimbursement debit card. This card provides you a $50 per month credit to use as you determine to cover unreimbursed medical expenses. You will receive additional information on this card.

2. BENEFIT CHANGES

Self-Funded Prescription Drug Plan

Prescription Solutions by OptumRx administers your pharmacy benefits on behalf of Automotive Industries Welfare Fund. Effective January 1, 2013, your plan is implementing a **Mandatory Generics Program for Multi-source drugs**, which encourages you to use generic versions of brand name medications when they are available. The Trustees have adopted the following changes:

- 3-Tier Formulary

  The prescription drug copayments will change from a 2-tier to a 3-tier structure on January 1, 2013, as shown on the table below:

Current Drug Copayments		
2-Tier	**Retail**	**Mail Order**
Generics	20% plus $5	$40
Brand	20% plus $5 (Max. of $100 copay at retail only)	$60

New Drug Copayments Effective January 1, 2013		
3-Tier	**Retail**	**Mail Order**
Formulary Generic	20% plus $5	$40
Formulary Brand (see section entitled "Mandatory Generic for Multisource drugs" below)	20% (Max. of $100 copay at retail only)	$60
Non-Formulary Brand and Generic	20% plus **$15** (Max. of $100 copay at retail only)	$60

- Mandatory Generic for Multi-Source Drugs

  A generic equivalent is the generic version of a brand-name medication. To gain U.S. Food and Drug Administration (FDA) approval, generic equivalents must prove to be just as safe and effective as their brand-name counterparts. In this program, when a generic equivalent is available and you choose to use the brand medication instead, you will pay full price for that brand name drug. After the patent expires on a generic drug and multiple manufacturers are allowed to produce therapeutic equivalents, a drug becomes a multi-source drug.

  You are not required to change from the brand name drug to the generic version, but you will pay full price for the brand medication starting January 1, 2013. If you use the generic equivalent instead, you will pay only your plan's copayment for formulary generic medications. In most cases, your pharmacist does not need your doctor's approval to fill your prescription with the generic equivalent instead of the brand-name medication.

  The prescription drug formulary includes brand name and generic medications that are covered under your pharmacy benefit plan. When your doctor prescribes a new medication, you will have a lower out-of-pocket amount if you use a drug on the formulary. If you are using a brand name medication, consider asking your doctor about a generic or a brand alternative. These drugs may be just as effective and could save you money too.

Generics, when available, offer you the greatest savings. They are safe, effective and reliable alternatives to higher priced brand products. Always check with your doctor to see if a generic product is available. Attached is the 2012 Comprehensive Outpatient Drug Formulary Wall Chart from OptumRx for your reference.

If you have any questions about this information or your pharmacy benefit plan, we encourage you to call Optum at 1-800-711-4555, Option 1. Customer Service Advocates are available to assist you 24 hours a day, 7 days a week.

Anthem Blue Cross Disease Management Core Programs

We are pleased to announce that the Trustees adopted a new Disease Management Core Program to help members improve their health and productivity. These include ConditionCare, 24/ NurseLine and MyHealth Advantage programs.

- **ConditionCare** uses a collaborative and holistic health management approach to help you better manage high-cost conditions such as asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease and heart failure.
- **24/7 NurseLine** provides access to a registered nurse over the phone 24/7, anytime, anywhere for assistance or just to hear a reassuring voice.
- **MyHealth Advantage** provides actionable and individualized messaging to you and providers about potential opportunities to improve health, optimize members health care spending, avoid critical health issues and address clinical gaps in care.

You will receive more information from Anthem Blue Cross on these important programs.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions.

If you have any questions, you may call the Fund Office at (800) 635-3105.

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 this Plan change, please contact the 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.