UAW RETIREE Medical Benefits Trust

TRUST QUARTERLY E-NEWS

For Union Benefit Representatives and Retiree Chairpersons

June 2014

Fall Retiree Meeting Schedule

Communicating benefit changes to our members is very important to the Trust. Just as we did last fall, Trust representatives will be available at Local and IAC meetings along with carrier representatives for your September through November retiree meetings. However, because of the number of meetings across the country and limited resources, the Trust and carriers will have a very tight schedule.

A Trust communications staff member will be reaching out to UBRs and Retiree Chairs by mid-August to schedule these meetings. **Please note, in order to meet all of the meeting requests, the Trust and carrier representatives will not be making repeat visits to locations during the fall months.**

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Mail Order Rx Update for Express Scripts Medicare Members

Effective January 1, 2014, there were important changes that affected mail-order home delivery services for Express Scripts Medicare members. New guidance from the Centers for Medicare and Medicaid Services (CMS) required members to provide consent on new and renewed prescriptions sent from a doctor directly to Express Scripts. On April 1, 2014, CMS relaxed its guidance and clarified with Express Scripts that members who have used mail order in the past 12 months will no longer need to provide consent. Express Scripts has changed their system with a 12-month look back.

Consent is only required for Medicare members new to the mail order process. When a new prescription is sent in on a member's behalf by their doctor either through fax or e-prescribing, the member will need to provide consent.

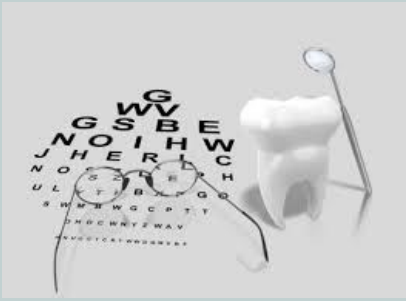
There are two ways to provide consent and request medication:

- Contact Express Scripts Medicare Customer Service at 866-662-0274, at the prompt, press 1. Customer Service is available 24 hours a day, 7 days a week. TTY users should call 800-716-3231
- Log on to www.Express-Scripts.com and select the prescription(s) to receive through home delivery. Members who have not been to the website before will need to register. They should have their prescription drug member ID card handy for the registration process.

For any new prescriptions requiring member consent, Express Scripts will contact the member through automated phone messages and/or by mail to obtain approval. Once consent is received, the prescription will be processed and mailed. Members do not have to provide consent for each refill.

Dental and Vision Announcement — GM and Chrysler

In 2012, the Trust added preventive dental and vision benefits for GM and Chrysler members. Effective January 1, 2015, the Trust is pleased to announce that the coverage will be enhanced to comprehensive dental and vision benefits for GM and Chrysler members and their eligible dependents.



The dental benefit will be administered through Delta Dental and the vision benefit will be administered through Davis Vision. (Ford members will continue to receive vision coverage through SVS.)

Eligible members should have received a letter with this announcement in late May. More information will be provided in the 2015 Benefits Highlights.

Medicare Accountable Care Organizations

More and more of our members are receiving letters from providers or doctors who have joined an accountable care organization (ACO).

An ACO is a network of primary care doctors, specialists and hospitals that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending. The goal of coordinated care is to ensure the patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

ACOs only apply to Original Medicare and do not impact Medicare Advantage products or members, but they aren't the same as a Medicare Advantage Plan or Health Maintenance Organizations (HMO). Members are still in Original Medicare, and their Medicare benefits, services, rights and protections won't change. Members still have the right to use any doctor or hospital that accepts Medicare at any time.

CMS requires Medicare ACOs to provide notifications to members asking if they want to participate in sharing their personal health information. These notifications could occur in person (at the provider's office) or by mail. The notice explains how the ACO intends to use the member's claims data. Protections are in place to ensure privacy, protect alcohol and substance abuse information and make sure data is limited to the minimum necessary. The data sharing is intended to make it easier to coordinate and improve the member's care.

Members have an opportunity to "opt-out" of the data sharing. The instructions for opting out are in the "Decline to Share" form included in the mailing. If the member does not take steps to decline data sharing within 30 days, data sharing between CMS and the ACO will occur automatically.

When the member's health care providers have access to their health information and are able to share that information with one another, it provides a complete picture of a member's health. **We encourage members to participate in ACOs as it leads to better, coordinated care.**

Accountable Care Organizations

About four million Medicare beneficiaries are now in an ACO, and, combined with the private sector, more than 428 provider groups have already signed up. An estimated 14% of the U.S. population is now being served by an ACO. Which are projected to save Medicare up to $940 million in their first four years.

We encourage members to participate in ACOs as it leads to better, coordinated care.

Important Reminders for Retiree Members

Share these important reminders with your members at your monthly retiree meetings.

Prescription Drug Large Print Instructions

Do you know a member who finds it difficult to read his or her prescription labels and instructions? Express Scripts is unable to attach larger print on the bottle labels but can include a copy of the bottle labels in large print as part of a patient's paperwork packet. The Patient Order Form contains a box stating, "Check here for a COPY of your bottle label in LARGE print on a separate sheet of paper." Express Scripts marks the account for this to occur on all future orders.

Express Scripts University of Arizona Drug Therapy Program

The University of Arizona handles both the Trust Medication Therapy Management (MTM) and the Personal Medication Coach (PMC) programs for Express Scripts.

The MTM program is a program required by CMS for all Medicare members. The PMC program is something the Trust added to address the same issues in the non-Medicare population. This is a program where a member will be contacted if they meet the criteria. This criteria includes having three (3) chronic disease states, such as hypertension, or diabetes, and the member is taking a least five (5) medications for these chronic conditions. Members are encouraged to participate as this could have a positive impact on their health, but they are given the option to opt out. If they participate, they will have a full review of their current medications, including over-the-counters and supplements they may be taking.

Members are also given the opportunity to ask questions and review what medication they are taking, why they are taking them and how they should take them. There are often tips and tricks the pharmacists can supply to make this easier for members. If the pharmacist has a concern, he or she will discuss with the member and even outreach to the physician if it helps the patient. They will also offer consultation on lower cost alternatives if the member's requests.

Sign Up for Pension Deductions

Remind members that if they do not currently have their monthly contribution deducted from their pension or bank account, we encourage them to contact RHCC at 866-637-7555 to authorize this form of payment. Automatic deductions will help avoid disruption in their Trust coverage.

Same-Sex Domestic Partnership / Spouse Eligibility Update

Members who currently have a same-sex domestic partner enrolled for health care coverage under the Trust can change their enrollment status to "spouse," provided that they are legally married.

A spouse under the Trust eligibility rules is defined as an individual married to a Retiree with a valid marriage certificate from a state, the District of Columbia, a U.S. territory, or a foreign country ("Jurisdiction") where such marriage has been recognized as legal according to the laws of that Jurisdiction, regardless of whether the Individual or Retiree is a current resident of that Jurisdiction.

There is an important benefit for a member in changing his or her same-sex domestic partner to a spouse. If they are legally married, and provide the Trust with a copy of a valid marriage certificate, the Trust will stop reporting imputed income to the IRS for the health care benefits provided to the same-sex domestic partner.

Depending on when the couple was married, imputed income for all of 2013 might be eliminated altogether. In addition, depending on the date of marriage, the member may be able to obtain a refund from the IRS for taxes already paid due to imputed income from the Trust. The member will need to consult a tax advisor to verify.

In states where same-sex marriage is legal, members **are not required** to get married in order to continue Trust coverage. However, a member cannot add a domestic partner to coverage after retirement. Members can add a spouse to coverage after retirement.

Members who are currently have a same-sex domestic partner enrolled for health care coverage should have received a letter from the Trust explaining this change.

In states where same-sex marriage is legal, members <u>are not required</u> to get married in order to continue Trust coverage. However, a member cannot add a domestic partner to coverage after retirement.

Members can add a spouse to coverage after retirement.

In Other News ....

<u>CareCore Radiology Pre-Authorization Pilot Ended</u>

More than 18,000 Trust members in <u>Indiana and Ohio only</u> in the BCBS TCN plan were part of a radiology pilot program with CareCore. As part of the pilot, non-Medicare members were required to get pre-authorization from CareCore before obtaining advanced imaging services. This pilot ended in mid-May and members are no longer required to obtain pre-authorization.

Affected members should have received a new ID card from Anthem and MMO in May with a short paragraph explaining the change. **There is no action required by members and their health care coverage does not change.**

<u>Express Scripts Phone Number Reminder</u>

There has been some confusion on the phone numbers for Express Scripts. Members can contact customer service at 866-662-0274.

The Trust has worked with each of our carriers to set up hotlines to assist UBR/Chairs who are assisting members. These hotlines will not be an effective resources if they are given out to members so **<u>please keep this for UBR reference and use only.</u>** The Express Scripts UBR Hotline number is 800-346-1325.

<u>Members with Dual Coverage</u>

During the last several months, the Trust has been mailing out letters to members who have dual medical coverage through the Trust as both a retiree and dependent or surviving spouse. Our intent for this letter is to share with the members that the double coverage is not always beneficial.

First, the two plans are coordinated which means the benefits paid are not duplicated. Once the primary plan has paid, there are no additional payments from the second plan.

Second, dropping one of the plans could save $16 or $32 (single versus two party coverage) in monthly contributions.

The following should be considered:

- Medicare Advantage PPO plans have a $0 contribution, lower cost share and are primary. Additional TCN coverage offers no benefit.
- To save money, members can elect separate coverage on their own or one member can elect to waive coverage.

A member can call Retiree Health Care Connect 866-637-7555 to review and make changes. If a member terminates coverage, they may re-enroll or change back at any time. In the end, the choice is theirs.