Colorado Finishing Trades
Health and Welfare Fund
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IMPORTANT: BENEFIT CHANGES EFFECTIVE JULY 1, 2018

As the Fund has continued to battle with the increasing cost of health care, it has become necessary at this time to enact some benefit changes in order to stabilize the financial position of the Health & Welfare Fund.

Please read this notice and the attached Summary of Benefits and Coverage ("SBC") closely to understand how your benefits are changing and contact the Administrative Office at 303-745-1941 or 1-800-659-0841 with any questions you may have.

Changes to Medical and Prescription Drug Benefits

The attached Summary of Benefits and Coverage ("SBC") details the benefits which will become effective with claims incurred on and after July 1, 2018. Please review this SBC carefully and contact the Administrative Office at 303-745-1941 or 1-800-659-0841 with any questions you may have regarding the new benefits.

As a result of these benefit changes, the Fund will now be a "non-grandfathered" plan under the provisions of the Affordable Care Act and, as such, will be adopting some changes which will provide you with enhanced preventive care benefits and greater limitations on your overall out-of-pocket exposure.

- **100% Coverage for In-Network ACA Preventive Care.** Starting July 1st, you will have access to 100% coverage – with no deductibles and no copays – for in-network services and prescriptions that are considered as preventive care under the provisions of the Affordable Care Act. This coverage includes routine physicals, cancer screenings, immunizations, and certain medications such as low dose statin therapy to prevent high cholesterol, birth control and smoking cessation.
- **Cost-Sharing Limitations.** Under your current benefits, amounts you pay for deductibles and copayments do not apply towards your maximum out-of-pocket. Under your new benefits, all amounts that you pay for deductibles, copay and coinsurance will apply towards satisfaction of the out-of-pocket amount, meaning that once you reach your out-of-pocket the Plan will pay 100% of all remaining covered charges for the rest of that calendar year. In addition, the Plan will also be adding a maximum out-of-pocket to the prescription drug benefit, so that if you reach the prescription out-of-pocket for prescription drugs, your copays will be waived for

- **External Appeals Process.** If you have a claim that is denied or partially denied, you have the right to appeal that denial to the Board of Trustees. The Fund will now be adding an additional level where, if you are dissatisfied with the decision on appeal of a medical or prescription drug claim that involves medical judgement, you can request that an external review of that claim appeal. The external review will be performed by a completely independent third party and the result of that review will be binding on the Fund. Requests for external review must be made within four months from receipt of the denial notice on your original appeal and all external review procedures will be completed in accordance with the provisions of the Affordable Care Act.

Important Information on the Prescription Drug Changes
In addition to changes in the copay levels for Brand drugs, there are some additional prescription drug changes that will impact how your prescriptions are covered.

Value Prescription Drug List – The Fund is changing its list of covered prescription drugs (the "formulary") from Cigna's standard list to the Value Prescription Drug List or Value PDL. The adoption of the Value PDL, along with the tiered copays for preferred and non-preferred brand drugs are to encourage appropriate utilization of generic drugs and more cost-effective brand medications. Under the Value PDL, some medications may be excluded from coverage altogether. This includes certain classes of drugs which have ample over-the-counter alternatives, such as non-sedating antihistamines, H2 antagonists and proton pump inhibitors (for heartburn and acid reflex). In addition, certain drugs in other categories may be excluded where there is significant cost savings by utilizing therapeutic equivalents. If you must take one of these excluded drugs, you can obtain coverage through a prior authorization process by establishing medical necessity.

Essential Protection – The Fund is adopting Cigna's Essential Protection drug utilization management program to help protect against potential drug misuse and rising drug costs. Under this program, coverage for prescriptions will be subject to additional utilization management processes, such as drug quantity limits, prior authorization to establish medical necessity and drug step therapy. With the quantity limits, coverage for a single prescription may be limited a supply level that is in line with FDA approved dosing guidelines. With prior authorization, coverage for certain medications will require that your doctor provide information regarding the medical necessity of the prescribed drug. Under step therapy programs, before the Fund will cover certain high cost medications, you will be required to first try a lower costing generic and/or preferred brand drug.

Changes to Vision and Dental Benefits

VISION: The Fund's Vision benefit, through Group Vision Services, will be terminating as of July 1, 2018. No coverage will be provided for vision services provided on or after that date.

DENTAL: The annual family limit for covered dental services will be reduced to $1,000 for services received on or after July 1, 2018. Please note that preventive and diagnostic services for eligibility dependent children under the age of 19 do not apply to this annual limit and will continue to be covered at 100% with no annual limit (please refer to your SPD for details on what is included in this pediatric preventive and diagnostic benefit).