Dear Member:

This flyer is designed to support you in addressing frequently asked questions (FAQs) regarding the changes to your Health Plan that went into effect on May 1, 2024.

For any questions you have that are not answered by this flyer, please contact the Participant Advocate – Joseph Geremina at the Local 812 Health Fund 516-303-1455, ext. 3. You are also encouraged to contact MagnaCare at 877-606-6701.

Here is a high-level overview of the changes:

EFFECTIVE MAY 2024		
	IN-NETWORK	**OUT-OF-NETWORK**
DEDUCTIBLE	$500 Individual $1,000 Family	$1,500 Individual $3,000 per family
COPAY	$40 Office Visits	None
COINSURANCE	None	You pay 30% of allowed charges
MAXIMUM OUT OF POCKET (In Network only)	$2,000 Individual $4,000 Family	None
EFFECTIVE JANUARY 2025		
	IN-NETWORK	**OUT-OF-NETWORK**
DEDUCTIBLE	$750 Individual $1,500 Family	Stays the same
COPAY	Stays the same	None
COINSURANCE	None	Stays the same
MAXIMUM OUT OF POCKET (In Network only)	Stays the same	None

What Are My Costs When I Go to an In-Network Doctor for my Annual Physical or for Any Preventive Services?

When you go to an in-network doctor for a yearly physical checkup or for any preventative service, there is no cost-sharing (no deductible or copay) for your visit.

Depending on your age, sex, and other risk factors, no-cost preventive services may include, but are not limited to:

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use
- Regular well-baby and well-child visits
- Routine vaccinations against diseases such as measles, polio, or meningitis
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Covered vaccines

You can find out more about preventive care services by going to https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html

What Happens if I go to an Out-of-Network Doctor for my Annual Physical or for Any Preventive Care?

If you use an out-of-network provider, the Fund will pay 70% of the Fund's allowance after the application of the deductible, if any, for the services provided. You are responsible for the other 30%. You may also be billed for the difference, if any, between the fee charged and the amount paid by the Fund ("balance billing"). Going to an in-network provider, therefore, will provide you with the best cost savings.

I Need to go to the Doctor (Other Than for my Annual Physical) but Haven't Met my Deductible. Do I Still Pay the $40 Copay?

The following examples illustrate how this works:

Example 1: You go to an in-network doctor before meeting your deductible. Your doctor's office may call MagnaCare and ask how much has been applied towards your deductible at the time of your visits. This in-network doctor has agreed to accept a fixed rate for your visit. If that amount is $150 dollars, and they are aware that $0 has been applied towards your deductible, you will be charged the full amount of $150. When the claim is submitted to MagnaCare, your EOB will show that $150 has been applied towards your deductible.

In some cases, your doctor's office may only charge you your co-payment of $40, without checking how much has been applied towards your deductible. When the provider submits their claim to MagnaCare, $150 will be applied towards your deductible. Since this provider has agreed to accept $150 as payment in full, you will be responsible to pay your provider the balance of $110.

You will not be responsible for paying the $40 copayment, until your deductible has been met.

Example 2: In this example you go to your doctor's office but $450 dollars has already been applied towards your in-network deductible, leaving $50 left to meet the $500 deductible. Same as Example 1, the doctors agreed upon rate is $150 – so in this scenario, if your doctor calls ahead to MagnaCare and is aware of how much of your deductible is left, they will ask for the $50 dollars that remain of your deductible, plus your $40 office visit copay. Once your deductible has been met, you will be responsible for your office visit copay of $40. When the doctor submits the claim to MagnaCare, your EOB will show $50 applied to the deductible, $40 copay and a payment to the provider of $60.

Once your deductible has been met, you will only be responsible for $40 for each office visit for the remainder of the year.

Please note that your in-network deductible and out-of-network deductible must be met separately. In-network expenses are not applied to your out-of-network deductible and vice versa.

How do the benefit changes affect when I go to an Out-of-Network doctor?

The only difference is that the Out-of-Network deductible has increased. Everything else remains the same.

Explanation of Benefits

Sometime after your visit, you will receive a letter from MagnaCare called an "Explanation of Benefits" or "EOB". An EOB is NOT a bill. Information stated on the EOB includes the following:

- The amount charged by the doctor
- The amount allowed by MagnaCare for the service provided
- The amount applied towards your deductible
- The amount you have already paid as a copay
- The amount for which you are responsible
- The amount remaining on your annual individual deductible and family deductible

Why Is It Important to Read and Keep My EOBs?

When you receive the bill from the doctor's office for your visit, the amount you are required to pay your doctor should match the amount in the EOB. If it does not match, you can call the Fund Office for support at 516-303-1455, ext. 3 or MagnaCare at 877-606-6701. Please note that the CREATE app is the fastest way to access EOB information directly on your phone. The CREATE app is also helpful in locating in-network services, such as doctors, urgent care centers, specialists, etc.

What Happens If I Go to the Doctor After I've Reached My Individual Deductible, but I Still Have a Family Deductible?

Benefits will be paid based on your having met your individual deductible. Other family members' benefits will be subject to their individual deductibles until the family deductible has been met. Once the family deductible has been met, there is no further need to meet individual deductibles.

What Will I Have to Pay If I Go to an Emergency Room?

If you go to the emergency room, any benefits payable will be subject to your remaining individual deductible, if any, and a $100 copay. You may also have to pay a $40 copay for the ER doctor.

If your visit to the ER results in you being admitted to the hospital as an inpatient, the $40 ER doctor copay and $100 ER facility fee will be waived.

I'm a Retiree and on Medicare. How Does the New Deductible Affect Me?

If you are a Medicare-eligible retiree, Medicare is your primary plan and the Local 812 Health Fund is your supplemental plan. This means that Medicare will be responsible for paying your benefits before the Health Fund starts paying any benefits. Because Medicare is primary and the Fund is secondary, you will not be required to meet the individual deductible before the Fund pays benefits.

How are my Dental and Vision Benefits Affected By the Change in Benefits?

Your dental and vision benefits are not affected at all. You are not required to meet any deductible in order to fully utilize your Dental and Vision Benefits. However, keep in mind that if you see an ophthalmologist, (s)he is a medical doctor. As a result, the deductible (if any) and copay would apply to the visit.

If you have any general questions, please contact the Fund Office at 516-303-1455, ext. 3. You can contact your dental and vision providers as follows:

Sele-Dent: 800-520-3368

Davis Vision: 800-999-5431

Vision Screening: 800-652-0063

How are my Prescription Benefits affected by the Change in Benefits? You are no longer required to pay 20% coinsurance for a generic drug prescription, regardless of whether you pick it up at your local pharmacy or have it mailed to your home. For name brand prescriptions, including specialty prescriptions, the 20% coinsurance has been increased to 30%. We recommend you ask your doctor to prescribe a generic drug whenever possible. The use of generic medication is the most effective way to minimize out-of-pocket costs.

How Does the Maximum Out-of-Pocket Limit ("MOOP") Protect Me and My Family?

The MOOP limits the amount that you have to pay each year for medical and hospital services to $2,000 per individual, $4,000 per family. Amounts paid for your deductible and copays count towards your MOOP. Once you have paid the MOOP for medical and hospital services, the Fund is responsible for the cost of care. The MOOP applies solely to in-network benefits. There is no MOOP for out-of-network expenses.

Although they are the same amounts ($2,000 per individual, $4,000 per family), there is a separate MOOP for prescription drugs.

What Will I Have to Pay For Diagnostic Tests?

If you are prescribed to take a diagnostic test (for example, an MRI, EKG or blood test), the doctor's office will most likely ask you for a $40 copay.

Some cancer screening tests (such as mammograms or colonoscopies) are considered Preventive Care and will not be subject to the deductible or copay. Any lab or pathology tests related to COVID-19 will be covered by your health plan, subject to a $40 copay.

Glossary of Terms

Balance Billing – When a provider bills you for the difference between the provider's charge and the amount paid by MagnaCare. Although in-network providers may bill you for amounts up to your deductible, they cannot balance bill you.

Coinsurance – A percent of the total cost for the service that you are required to pay to a provider.

Copay – A fixed out-of-pocket amount for covered services. If you use an in-network provider, you would ONLY be billed above your copay up to your deductible.

Cost sharing – The amount you pay to a provider for covered services, such as copayments, deductible and/or coinsurance.

Deductible – The amount paid **before** the Fund covers costs or when copays would apply. The deductible applies before any copayments or coinsurance.

Maximum Out of Pocket Limit – The most you pay for covered services during a calendar year.

You can find definitions of other commonly used terms related to coverage by the Plan by going to https://www.healthcare.gov/sbc-glossary/