



SHEET METAL WORKERS' LOCAL UNION NO. 28 FUNDS AND PLANS METROPOLITAN NEW YORK AND LONG ISLAND

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EXECUTIVE DIRECTOR
GLEN CAMISA

To: All Eligible Participants in the Sheet Metal Workers Local 28 Welfare Fund

Date: October 15, 2015

The use of In-Network vs. Out-of-Network Providers

As you know, your medical and hospital benefits are provided through the BlueCross BlueShield / Anthem preferred provider program (PPO). Blue Cross Blue Shield has a vast network of over [650,000] participating doctors, hospitals, medical facilities, and other medical providers. Because of its size, Blue Cross Blue Shield receives discounts from providers that are not available through other networks and/or from out of network providers. These savings are passed on to you and the Welfare Fund which helps keep the cost of the medical and hospital program as low as possible so that the Fund can continue to deliver quality benefits to you and your family.

Deciding what provider to use is your choice. There are many reasons as to why you should use a provider that is within the Blue Cross Blue Shield network. First, providers that are within the network are carefully evaluated and must meet many qualifications before they are accepted to participate in the network. Next, the concern and worry about your claims being paid will be virtually seamless for you. Last, but not least, there will be less of an out-of-pocket expense for you and **the Welfare Fund**. Below are some examples.

Using an In-Network (Participating) Provider

Currently, if you use an in-network provider or facility **some** services require a copay. The copay for a basic office visit is \$20, \$35 for an emergency room, and \$250 for an inpatient hospital stay. If you use an in-network provider, you will only be responsible for these copays. There will be no balance billing. There are similar copays for some of the Plan's other basic services. Please refer to your Summary of Benefits and Coverage (SBC) or the Summary Plan Description (SPD) for more details.

It is important to note that before you make a medical appointment, you should ask your provider if they **PARTICIPATE** with the local Blue Cross Blue Shield PPO Plan. The www.anthem.com website is only a guide. Even though a provider is listed on the website, you should call to make sure that they are still an in-network provider. **In addition, if you are receiving medical services that require multiple providers, you need to make sure that all the providers treating you PARTICIPATE or you might be responsible for additional charges above the copay as discussed below.**

So, what does that mean for you and the Fund? Let's say for example you use an in-network provider for an office visit and that provider normally charges \$500.00 for that visit. You would only be responsible for the \$20 network copay. Because the provider participates with Blue Cross Blue Shield, they will be reimbursed at the negotiated rate which would be something much less than their normal charges. Many times it can be 50-75% less than the billed charges.

Using an Out-of-Network (Non-Participating) Provider

If you decide to use a provider that does not participate with Blue Cross Blue Shield, you will most likely be responsible for additional costs. In addition to the copays that are charged for in-network services, your provider might balance bill you for amounts that they charge which are in excess of the Plan's Maximum Medical Allowance (MMA). The MMA rate is determined as follows. These additional charges are also known as coinsurance. Please note that the copay for basic office visits for when you use an out-of-network provider is \$30, not \$20 as it is for using an in-network provider.

- a. For institutional (hospital and facility) services, the MMA is determined based upon rates provided by EMC/Captiva at the 50th percentile;
- b. For professional services, MMA is determined based upon the National Medicare fee schedule at 100% with the exception of the following two services:
 - Office visit for evaluation and management of established patient – CPT 99213 – the MMA rate allowance is \$40
 - Office visit for evaluation and management of established patient, detailed – CPT 99214 – the MMA rate allowance is \$60

Examples:

Let's say you decide to use an out-of-network provider for an office visit and that provider normally charges \$500.00 for that visit and the Plan's MMA rate was determined to be \$60.00. First, you would still be responsible for the \$30 out-of-network copay which is your share of the Plan's reimbursement to your out-of-network provider. So, the Plan would pay \$30 and you would pay \$30. **In addition to your \$30 copay, your out-of-network provider will most likely bill you for the balance of the unpaid charges.** In this case, that would be an **additional \$440** (\$500 that is billed by your out-of-network provider, less your \$30 copay, less \$30 paid by the Plan = \$440). **Therefore, your total out-of-pocket expense could possibly be \$470** (your \$30 copay plus the \$440 balance bill) **rather than just a \$20 copay if you went in-network.**

Next, suppose you went to an out-of-network hospital that charges \$1,500 for an overnight stay and the MMA amount is determined to be \$750. You will most likely be responsible for \$1,000 of that bill. Again, you will be responsible for your copay which in this case which would be \$250. Then, after the Plan pays its allowance of \$500 (\$750 MMA less your \$250 copay), there would be a balance of \$750 that your out-of-network provider might try to collect from you. **Therefore, your total out-of-pocket expense would be \$1,000** (your \$250 copay plus your out-of-network providers balance bill of \$750) **rather than just the \$250 copay if you went in-network.**

Lastly, in the more extreme case, let's say you scheduled elective surgery with out-of-network providers and the total charges being billed for all institutional hospital, facility and physician service were \$100,000 and the MMA was determined to be \$20,000 (combined facility and physicians) which will be offset by your \$250 copay. **You might be at risk of being balanced billed \$80,250** (\$100,000 billed by your out-of-network providers, less your \$250 copay, less \$19,750 reimbursed by the Plan = \$80,250). In this case, if you would have used network providers, you would have only been responsible for your \$250 copay and the Plan would have been billed a significantly lower amount based on the Blue Cross Blue Shield negotiated rate.

Please note that these examples are for illustrative purposes only. Your out-of-pocket expense could be much different depending upon the nature of your medical needs, the prices that your out-of-network provider charges, and the MMA determined by the Plan. However, they are close to real cases that the Fund has seen. The advantages of using in-network providers for the Plan's dental, mental health and substance abuse, prescription drug, and vision programs are very similar.

Should you have any questions concerning the use of in-network versus out-of-network providers, or any of the Plan's other benefits and provisions, please do not hesitate to contact the Fund Office at 516-742-9478.

This Notice is intended to constitute a summary of material modifications under the Employee Retirement Income Security Act of 1974, as amended, and to provide you with an easy-to-understand description of certain important changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this Notice cannot contain a full restatement of the terms and provisions of the Plan. For a full description of your rights under the Fund, please refer to the plan documents (including the SPD). If any conflict should arise between this Notice and the Plan documents, or if any point is not discussed in this Notice or is only partially discussed, the terms of the Plan documents will govern in all cases. The Board of Trustees of the Sheet Metal Workers Local 28 Welfare Trust Fund, or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan or any benefits provided under the Plan (or eligibility for such benefit) in whole or in part, at any time and for any reason.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.