Benefit Enrollment for 2023

Enrollment deadline: 11:59 p.m. Nov. 30, 2022

Let's take it from the top…

Don't skip to the end and simply keep what you already have. Take just a few minutes to review your options to ensure you have the coverage that's best for you.

Both plans cover the same health services, supplies and prescriptions. Both use the same network of doctors and hospitals. The difference is how much you pay depending on how you use the plan.

Review this guide to learn about the Healthy Savings Plan (formerly Plan A1) and how it compares to the Standard Plan (formerly Plan A).

What You Need to Know

You Have Options

This is your chance to review the programs AGMA Health Fund offers and learn about the changes for 2023.

Choose from two plans for your medical coverage:

- **Healthy Savings Plan** (formerly Plan A1) – A high deductible plan with employer contributions to your personal health savings account (HSA). You pay no premium for this plan for individual coverage and $1,370 per month for family coverage.
- **Standard Plan** (formerly Plan A) – This plan has a lower deductible and pays more for services up-front, but you pay $40 per month for individual coverage and an additional $1,839 per month for family coverage.

See pages 8-9 for a comparison of the key features so you can select the plan that's best for you.

2023 Changes

Healthy Savings Plan

- New for 2023, half of the maximum annual contribution your employer makes to your HSA will be made in January (or when your benefits start, if later), the other half will be contributed later in the year. The total annual employer contribution amount stays the same: up to $1,000 for single coverage or $2,000 for family coverage.
- The amount you pay for generic medications is decreasing (after you meet your deductible) effective January 1, 2023 — your coinsurance will be 15%, after deductible.

2023 Changes continued

Standard Plan

- The **copayments for some in-network services** are increasing as follows:
  - High-cost radiology: $50 per visit
  - Inpatient hospital stays: $300 per stay
  - Outpatient surgery: $200 per surgery
- The **out-of-network deductible** is increasing to $4,000 per person / $8,000 per family, and the **out-of-network out-of-pocket maximum** is rising to $8,000 per person / $16,000 per family.
- Cost-sharing at in-network pharmacies is changing for **generic and non-preferred brand name drugs:**
  - Generic: 15% coinsurance after prescription drug deductible (a decrease from 20%)
  - Preferred brand: 25% coinsurance after prescription drug deductible (no change)
  - Non-preferred brand: 37.5% coinsurance after prescription drug deductible (an increase from 35%)
- There will be a new program through PrudentRx to provide **some specialty medications at no cost** to you. See page 9 for details, including where to get your drugs and the cost for your prescriptions if you opt out.

What You Need to Do

Enroll online at
http://www.portal.agmaretirement-health.org/
or return the enclosed enrollment form
to the Fund Office by Nov. 30, 2022.

You need to enroll if you want to make changes to your coverage for 2023:

- **Switch from the Standard Plan to the Healthy Savings Plan, or vice versa**
- **Enroll in or drop dental and/or vision coverage**
- **Add or drop dependent coverage**

What if I Don't Enroll?

If you do nothing, you will keep the same coverage options you have now. Plan design changes for 2023 will apply to you.

2023 Premium Rates

The premiums below are the full member rates. The amount you pay depends on your collective bargaining agreement.

	Single Coverage	Family Coverage (additional)
Healthy Savings Plan	$0	$1,370/month
Standard Plan	$40/month	$1,839/month

Are You Ready to Make the Leap?

The Healthy Savings Plan, introduced in 2022, is a Health Savings Account (HSA)-eligible high deductible health plan.

The Healthy Savings Plan is similar to the Standard Plan:

- It's administered by Aetna and has the same network of providers.
- It covers the same services and has the same list of covered prescriptions.

What makes the Healthy Savings Plan different?

- You pay zero premium for individual coverage.
- You receive employer contributions to a Health Savings Account (HSA) to use for eligible expenses – up to $1,000 for single coverage / $2,000 for family coverage in 2023.
- You also have the option to contribute your own money to your HSA (up to IRS limits) – these contributions may be tax free if they are deducted from your wages (depending on your employer) and are tax deductible if you make them directly, can build up year over year, earn interest, and can even be invested.
- It has a higher annual deductible than the Standard Plan.

PLEASE NOTE: The Healthy Savings Plan deductible applies to both medical and pharmacy costs. This means that the cost for most prescriptions (except for preventive drugs) will not be covered until you meet your annual deductible.

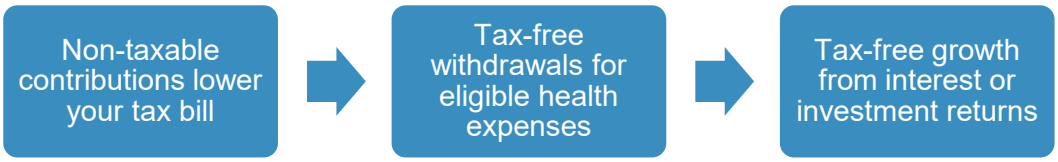
Take a look at the plan comparison on pages 8 and 9 to review the key features of each of your medical plan options.

Get $500 Of Your HSA Money In January!

New for 2023: If you're covered by the Healthy Savings Plan at the start of the year, the first half of your employer HSA contribution will be loaded into your account in January so you will have funds to use right away. The other half will be contributed later in the year.

Health Savings Account Advantages

Triple Tax Savings



- Money is not taxed when it goes into your account, or when it comes out (as long as you use it for eligible expenses)
- It gives you an additional tax-advantaged way to save on top of any retirement savings
- It lets you save up for a planned or unexpected medical expense, or save for healthcare expenses in retirement

Use Your HSA for IRS-Approved Healthcare Expenses

- For you, your spouse and/or your eligible tax dependents – whether enrolled in the Healthy Savings Plan or not
- Now, or in the future – even during retirement
- Once you're enrolled in Medicare, you can't contribute to an HSA but you can still withdraw money tax-free to pay healthcare expenses

Your HSA Belongs to You

- You decide when and how to spend it
- You keep it if you switch health plans, change jobs or retire
- There is no "use it or lose it"
- You can withdraw money for non-medical reasons, but you'll need to pay taxes on it

Health Savings Account Rules

HSAs provide significant tax savings and that means there are IRS rules attached. It's important to know about these rules because it's up to you to be sure you're following them. If you are eligible for AGMA Health Fund benefits, you can enroll in the Healthy Savings Plan. But, whether or not you can also contribute to the HSA is subject to IRS rules. Go to www.irs.gov and search for form 969 to learn more.

HSA Contribution Limits

For the 2023 calendar year, the IRS limits what can be contributed to an HSA. This limit is a combination of what your employer contributes and any contributions you make.

If you want to make personal contributions to your account, you can start, stop or change your personal contribution amount during the year – you don't have to wait for open enrollment.

	Employer Contribution	Personal Contribution Allowed	Total Allowed
Single Coverage	$1,000	$2,850	$3,850
Family Coverage	$2,000	$5,750	$7,750
Age 55 or older in 2023?	Add an additional catchup contribution of up to $1,000		

Note – It is your responsibility to ensure that the combination of your contributions and your employer's contribution does not exceed the IRS limit for the year.

Using the Health Savings Account

- By enrolling in an HSA, you are authorizing Zenith American to open an individual bank account in your name and, if you choose to contribute, contributions may be tax free if they are deducted from your wages (depending on your employer) and are tax deductible if you make them directly. You have to have funds in your HSA before they can be withdrawn. With the up-front employer contribution, you'll have funds to use right away
- If you have a large expense early in the year and don't have enough in your account yet to cover it, you'll have to pay out of pocket. However, if you are also building your account with your own contributions, you can file a claim later when you have enough funds to reimburse yourself. (You can arrange with Zenith to have reimbursements directly deposited into your bank account.)
- Your funds can be accessed with a payment card, direct pay to providers, or by filing a claim.

Want to know more? Visit www.investopedia.com/terms/h/hsa.asp for more on how health savings accounts work in general or call the Fund Office.

Benefit Tip

Remember, in-network preventive care is covered 100%, no matter which plan you choose.

Choosing the Right Plan for You

Which plan is right for you and your family? Here are some scenarios to help you consider which plan might best meet your needs.

Claire uses her medical coverage occasionally

Claire is active and has no chronic health conditions. She rarely spends more than $500/year on health care.

Here's why Claire chooses single coverage in the **Healthy Savings Plan**:

- No monthly premiums deducted from her paycheck – she would rather use that $40 per month for other things.
- Her in-network preventive care is covered in full – for anything else, she will pay the full amount until she meets her deductible, but she can use her health savings account (HSA) money to cover some or all of those out-of-pocket expenses.
- She expects to spend less than the $1,000 her employer will contribute to her HSA and is happy to build up her account balance to use later when she needs it.

Thomas has multiple medical conditions

Thomas has a surgery planned for next year that will require that he stay in the hospital for a night or two. Currently, he takes a couple of brand-name prescriptions and sees his chiropractor regularly for a back issue. Thomas covers his family on the Plan as well.

Here's why Thomas chooses the **Standard Plan**:

- Having a fixed copay amount for his upcoming in-network hospital stay makes paying the monthly premium worth it to Thomas.
- Thomas likes that he'll only pay $50 for his first in-network chiropractor visit of the year, and then nothing more after that. (A medical review is required to continue chiropractor visits after 25 sessions.)
- Knowing that he'll have significant medical expenses next year, he feels more comfortable with no deductible for medical services and a low prescription drug deductible.
- He plans to save on his prescriptions by using mail order.

Sonia is looking toward retirement

With retirement on the horizon, Sonia wants to maximize her savings to spend on healthcare after she stops working.

Here's why Sonia chooses single coverage in the **Healthy Savings Plan**:

- No monthly premiums deducted from her paycheck – she can contribute that $40 per month to her health savings account (HSA) instead.
- Between the $1,000 employer contribution and her own contributions, which may be tax free or tax deductible, she can build her account and save it for post-retirement medical expenses.
- In a typical year, Sonia gets her preventive care and sees the doctor a few times; in case of emergency, with her employer and personal HSA contributions, she has nearly enough saved to cover the in-network deductible.

Sonia's HSA Savings Help Cover Her Deductible

- Sonia puts the $40/month she would have paid for the Standard Plan into her HSA:

  $40x12 months = $480

- That amount is added to the $1,000 employer contribution:

  $1,000 + $480 = $1,480

- Sonia's annual deductible is $1,700, but she will have $1,480 in her HSA; leaving her with only $220 to pay out-of-pocket on her deductible:

  $1,700 - $1,480 = $220

- Any HSA money Sonia doesn't use will roll over to the next year and beyond!

Consider This…

If…	…then the **Healthy Savings** Plan might be a better choice for you	…then the **Standard** Plan might be a better choice for you
You mainly use your medical coverage for preventive care, the occasional office visit, and a couple of generic prescriptions	X	
You have a surgery and hospital stay planned for next year		X
You want to save money for medical care in retirement	X	
You see a chiropractor frequently		X
You feel comfortable covering the deductible, if needed	X	

Medical Plans Benefit Summary

Changes for the 2023 plan year are shown in **bold blue** font in the chart below.

Plan Features and Benefits	Healthy Savings Plan		Standard Plan	
	In-network	Out-of-network	In-network	Out-of-network
How It Works	Administered by Aetna; use an in-network provider and receive higher benefits		Administered by Aetna; use an in-network provider and receive higher benefits	
Health Savings Account Employer Contribution	Up to $1,000 single coverage / $2,000 family coverage ($83 single coverage / $167 family coverage per month you are eligible)		Not available	
Deductible	$1,700 per person / $3,400 per family (combined for medical and prescription drugs)	$3,000 per person / $6,000 per family	Medical: none Prescription drugs: $75 per person / $150 per family	**$4,000 per person / $8,000 per family**
Annual Out-of-Pocket Maximum (includes deductible)	$3,000 per person / $6,000 per family	$6,000 per person / $12,000 per family	$3,000 per person / $6,000 per family	**$8,000 per person / $16,000 per family**
Chiropractic Care (medical review required after 25 visits)	*After deductible*, $50 copay per visit	*After deductible*, you pay 40%*	$50 copay for first visit per year, $0 for subsequent visits	*After deductible*, you pay 30%*
Diagnostic Tests, Labs and X-rays	*After deductible*, you pay 20%	*After deductible*, you pay 40%*	$20 copay per visit	*After deductible*, you pay 30%*
High-cost radiology (i.e. CTs, MRIs, PET scans)	*After deductible*, you pay 20%	*After deductible*, you pay 40%*	**$50 copay per visit**	*After deductible*, you pay 30%*
Emergency Room (waived if admitted)	*After deductible*, you pay 20%*		$150 copay per visit	
Hospital Stay	*After deductible*, you pay 20%	*After deductible*, you pay 40%*	**$300 copay per stay**	*After deductible*, you pay 30%*
Office Visit	*After deductible*, $30 copay per visit for primary care / $50 copay per visit for specialist care	*After deductible*, you pay 40%*	$30 copay per visit for primary care / $50 copay per visit for specialist care	*After deductible*, you pay 30%*
Outpatient Rehabilitation (physical, occupational, speech)	*After deductible*, $50 copay per visit	*After deductible*, you pay 40%*	$50 copay per visit	*After deductible*, you pay 30%*
Outpatient Surgery	*After deductible*, you pay 20%	*After deductible*, you pay 40%*	**$200 copay**	*After deductible*, you pay 30%*
Prescription Drugs	See page 9			
Preventive Care	You pay $0 (no deductible)		You pay $0	
Urgent Care	*After deductible*, you pay 20%	*After deductible*, you pay 40%*	$75 copay per visit	*After deductible*, you pay 30%*

*Percentage plan pays is based on the recognized charge. If your out-of-network provider's charges exceed the "usual and customary" charge, you pay the excess in addition to your coinsurance percentage.

Prescription Drug Benefit Summary

	Healthy Savings Plan		Standard Medical Plan	
	Retail Pharmacy (up to a 30-day supply)	**Mail-order** (up to a 90-day supply)	**Retail Pharmacy** (up to a 30-day supply)	**Mail-order** (up to a 90-day supply)
Annual Deductible	You pay a combined medical/prescription drug deductible of $1,700 per person ($3,400 per family) a year before the Plan begins to pay benefits.		You pay a deductible of $75 per person ($150 per family) per year before the Plan begins to pay benefits.	
Preventive	You pay $0, no deductible		You pay $0, no deductible	
Generic	After deductible, you pay **15% (in or out-of-network)**	After deductible, you pay 15%	After deductible, you pay **15% in-network** or 30% out-of-network	After deductible, you pay 15%
Preferred Brand	After deductible, you pay 25% (in or out-of-network)	After deductible, you pay 25%	After deductible, you pay 25% in-network or 30% out-of-network	After deductible, you pay **25%**
Non-preferred Brand	After deductible, you pay 37.5% (in or out-of-network)	After deductible, you pay 37.5%	After deductible, you pay **37.5% in or out-of-network**	After deductible, you pay 37.5%
Specialty	Same as above depending on which tier drug falls into (generally Preferred Brand)*	Same as above depending on which tier drug falls into*	**If you participate in the PrudentRx Copay program, you will have $0 copayment for drugs covered under the Program** If you do not participate, you will pay 30% coinsurance for those drugs.** Specialty drugs not covered under the PrudentRx Copay Program will have coinsurance as described above based on whether the drug is a Generic, Preferred Brand or Non-preferred Brand (generally Preferred Brand)*	

*The first prescription fill for specialty drugs (that are not covered by the PrudentRx Copay Program) may be obtained from a retail or specialty pharmacy; subsequent fills must be through the Aetna Specialty Pharmacy Network. The cost is as applicable above.

***All prescriptions included in the PrudentRx Copay Program must be obtained through the Aetna Specialty Pharmacy Network.**

**New Specialty Drug Program for Standard Medical Plan

As part of your prescription benefit under the Standard Plan, the PrudentRx Copay Program allows you to get select specialty medications at no cost to you. You must fill your specialty prescriptions under this program through Aetna Specialty Pharmacy Network This program will go into effect Jan. 1, 2023.

How do I know if I'm eligible?

If you currently enrolled in the Standard Medical Plan and take one or more medications included in PrudentRx's Specialty Drug List, you will be automatically enrolled and receive a welcome letter and phone call from PrudentRx. If you have been newly prescribed a specialty medication, you will need to contact PrudentRx to enroll. For more information or to enroll, please call PrudentRx at 1-800-578-4403.

How does the program work?

PrudentRx works with drug manufacturers to get copay assistance (a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications). PrudentRx will manage the enrollment and renewals in these copay assistance programs on your behalf. Even if there is no copay program for your medication, your cost will be $0 for as long as you are enrolled in the PrudentRx program.

Dental Plan Overview

If eligible, self-pay dental coverage is available from Aetna Dental, costs $22.62 per month for individual coverage and $64.80 per month for family coverage (payable directly to the Fund Office and in advance of the coverage month).

You can choose either Aetna DMO or Aetna Traditional coverage:

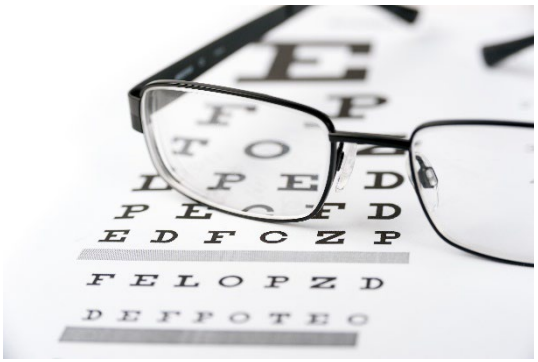
- **Aetna DMO Plan** has no deductible and no-cost preventive care, but you must use Aetna DMO dentists.
- **Aetna Traditional Plan** coverage allows you to see in-network or out-of-network dentists, but your out-of-pocket costs are higher.

	DMO Plan (at DMO network provider)	Traditional Plan (at any dentist)
Annual Deductible	No deductible	$100 (individual) $300 (family)
Annual Benefit Maximum	None	$1,000
Preventive services: • **Exam** • **X-rays** • **Cleanings** • **Fluoride**	$0; Plan pays 100%	Plan pays 80% of usual and customary fees
Basic Services	Plan pays 80%	Basic services like fillings, extractions, and root canals and major services like crowns, implants, and dentures are covered according to a schedule of benefits (a set dollar amount for each service). To see the benefit amounts for specific services, please refer to the Traditional Plan benefit summary posted on www.agmafunds.org.
Major Services	Plan pays 50%	
Orthodontia	Not covered	Not covered

Vision Plan Overview

Vision coverage, provided by Aetna, costs $3.51 per month for individual coverage and $8.37 per month for family coverage (payable directly to the Fund Office and in advance of the coverage month).

In addition to the benefits summarized below, Aetna also offers discounts for additional pairs of eyeglasses.



		In Network	Out of Network
Routine Exams – Use your exam benefits once every rolling 12 months.			
Routine Eye Exam	Eye exam with dilation as necessary	$25 copay	$15 reimbursement
	Retinal imaging	$39 copay	Not Covered
	Standard contact lens fit/follow up	$40 copay	Not Covered
	Premium contact lens fit/follow up	You pay 90% of retail	Not Covered
Lenses – Use your lens benefit once every rolling 12 months to purchase **either** one pair of eyeglass lenses OR one order of contact lenses.			
Standard Plastic Lenses	Single vision	$25 copay	$10 reimbursement
	Bifocal	$25 copay	$25 reimbursement
	Trifocal	$25 copay	$55 reimbursement
	Lenticular	$25 copay	$55 reimbursement
	Standard progressive vision lenses	$90 copay	$25 reimbursement
	Premium progressive vision lenses	$90 copay, you pay 80% of the retail price less the $120 allowance	$25 reimbursement
Contact Lenses	Conventional	$0 copay; $100 allowance, 15% off balance over allowance	$70 reimbursement
	Disposable	$0 copay; $100 allowance	$80 reimbursement
	Medically necessary	Covered in full	$200 reimbursement
Frames – Use your frame benefit once every rolling 24 months.			
Any frame available, including frames for prescription sunglasses		$0 Copay; $100 Allowance, 20% off balance over allowance	$50 reimbursement

Cost Example

Jane hasn't had new glasses in three years. She picks out frames and lenses from an in-network provider. The retail cost of the frames are $200. Her lenses are premium progressive vision lenses with a retail cost of $300. Here's the math on how much Jane will pay.

Frames:

$200 - $100 allowance = $100

$100 - 20% discount = **$80**

Lenses:

$300 charge x 80% = $240

$240 - $120 allowance = $120

$120 + $90 copay = **$210**

Total:

Jane's out-of-pocket cost for lenses and frames:

$80 + $210 = **$290**

Covering Your Dependents

See the summary plan description for the definition of eligible dependents.

Generally, you have 30 days to add new dependents during the year. Contact the Fund Office right away when you add to your family at info@agmafunds.org.

If you have coverage that includes your dependent children, they may continue on your medical, dental, and vision coverage until the end of the month in which they turn age 26.

Questions?

If you have any questions, please contact the Fund Office by phone at 212-765-3664 or e-mail at info@agmafunds.org.

This guide contains an overview of the AGMA Health Fund benefit program. Although we have made every effort to ensure it is accurate, provisions of the official plan documents and contracts will govern in the case of any discrepancy. Please contact your personal tax advisor regarding the tax impact to you of any benefits described herein.

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes to the AGMA Health Fund plans of benefits (collectively, the "Plan") referenced herein. Please read this SMM carefully and keep it with the copy of the Summary Plan Description ("SPD"), SMMs, and other information that was previously provided to you concerning Fund benefits. If you need another copy of the SPD or if you have any questions regarding these changes, please contact the Fund Office during normal business hours at 305 7th Ave, Suite 2B, New York, NY 10001, (212) 765-3664.

This SMM is intended to provide you with an easy-to-understand description of certain changes and/or clarifications to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees 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, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement is available at the Fund Office and may be inspected by you free of charge during normal business hours.

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.