AGMA Health Fund
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AGMA HEALTH FUND – Changes to PLAN A Coverage 1/1/18

Dear AGMA Health Plan A Participant:

The Trustees of the AGMA Health Plan recently conducted a thoughtful review of the benefit plan experience and future cost projections. We are sure that you have heard in the press and social media about how health care expenses continue to rise at a rate greater than that of inflation, and, in particular, prescription expenses have surged ahead at even higher rates for our plan.

After lengthy deliberations, the Trustees have decided to make adjustments to certain benefits in the Aetna coverage, after a long period without such changes. We believe that even with these changes, AGMA Health Plan A will continue to be a very strong plan, particularly when compared with the coverage available through the Marketplaces. Plan A will also continue to provide "minimum value" coverage under the Affordable Care Act.

Starting January 1, 2018, the following changes will go into effect for participants in Aetna's Open Access Managed Choice plan for the medical services indicated below. Please see the attached Summary of Benefits and Coverage (SBC) for more information.

- The network specialist physician co-pay will increase from $35 to **$45**. The network primary care physician co-pay will remain unchanged at $30. Participants will continue to not be required to select a primary care physician under the network and referrals to specialists are still not required. There will be no change in the deductible for in-network services **(**$0**)** and the in-network reimbursement will remain at 100%. There will be no change in the out of network deductible of $1,000 for individuals and $2,000 for families.

- The co-pay for an urgent care facility will increase from $50 to **$75**.

- The co-pay for an emergency room visit will increase from $100 to **$150**. The facility fee for a hospital admission will remain unchanged at $100.

- The prescription drug coverage deductible will change from $50 to **$75** for individuals and from $100 to **$150** for family coverage.

- Prescriptions that are available as a generic will be **required to be filled as a generic**, unless there is a medical necessity for an alternative.

- The co-pay for retail pharmacy brand prescription coverage will increase from 20% to **25% for Preferred Brand Prescriptions**.

- The co-pay for mail-order pharmacy brand prescription coverage will increase from 15% to **20% for Preferred Brand Prescriptions** and from 15% to **25% for Non-Preferred Brand Prescriptions**.

- Prescriptions will be subject to new policies regarding **Precertification** and **Step Therapy**. **Precertification (Prior Authorization)** is a type of drug coverage review or checkpoint. It checks prescribed drugs to make sure they meet certain criteria to be considered medically necessary. **Step Therapy** is another type of drug coverage review. In some cases, members are required to try certain drugs first before coverage is granted for another drug for the same condition. Step Therapy is often used in crowded drug classes to help members make cost-effective drug choices.

As noted above, some of the changes to the Prescription Coverage will result in a change in how you may get some of your medications. These changes were made to help save you and the Plan the cost of a more expensive prescription when a more cost-effective alternative is available. Aetna will send a letter to any member currently taking medication that will be affected by the Precertification and/or Step Therapy programs.

Aetna has a program called **Transition Fill** that is available for one-time use and helps members currently taking medications that are subject to Precertification or Step Therapy. During their first 90 days of coverage under Precertification and Step Therapy, such members can get a one-time fill of most drugs that require Precertification, Step Therapy or for drugs that may no longer be covered. Transition Fill does not apply to specialty medications or "Safety edits," under which a claim may be denied due to safety concerns about the medication. Members will also receive a letter telling them the steps that need to be taken under their new benefits. Restrictions may apply.

The Fund Office is working with our Aetna representatives to make the transition as smooth as possible for all members. While you will not receive a new member card in the mail from Aetna, you will be able to print your new benefit information by logging in at www.Aetna.com on January 1, 2018. In addition, you will be able to digitally display your new information by using the Aetna Mobile app on January 1, 2018. You may call Aetna member services at (866) 658-2455 for help with this process. You may also call our office after January 1 and we will be glad to assist you in obtaining an updated card.

COBRA rates will be updated as of January 1 and will be sent at the regular billing time. The regular contribution rate of $934 for individual coverage and additional $1,383 for family coverage will not change.

The health care industry continues to evolve due to changes in the types and costs of services provided by medical professionals and the requirements of laws and regulations. The Trustees actively monitor the status of the Plan A benefit options and seek to provide a plan that offers benefits to our participants who have diverse health care needs. The Trustees seek to provide you with valuable health care coverage in the most efficient and cost-effective manner possible.

Please call the Fund Office at (212) 765-3664 or email us at info@agmafunds.org or at agmaretirement_health@yahoo.com if you have any questions and we will get back to you as soon as possible.

Sincerely,

Derek J. Davis
Executive Director
For the Board of Trustees
AGMA Health Fund