AGMA HEALTH FUND
Proposed Effective Date: 01-01-2025
APCN Aetna Choice® POS II -- ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
Deductible (per calendar year)	$1,700 per Individual $3,400 per Family	$3,000 per Individual $6,000 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Once you meet the family deductible, then all family members have met it for the rest of the year. There is no individual deductible for members of a family.		
Member coinsurance	You pay 20%	You pay 40%
Applies to all expenses except as noted.		
Out-of-pocket limit (per calendar year)	$3,000 per Individual $6,000 per Family	$6,000 per Individual $12,000 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.		
Lifetime maximum		
Unlimited except where otherwise indicated.		
Precertification requirements -		
Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by $400 or 50%. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts. **Network Designations**- In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may be paid at the out-of-network benefit level or may not be covered at all.		
PREVENTIVE CARE	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Routine adult physical exams/ immunizations	Covered 100%; no deductible	Covered 100%; no deductible
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older		

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Routine well child exams/immunizations/pediatric eye exam • 7 exams in the first 12 months • 3 exams from age 13 to 24 months • 3 exams from age 25 to 36 months • 1 exam every 12 months thereafter until age 22	Covered 100%; no deductible	Covered 100%; no deductible
Routine gynecological care exams 2 exams and pap smears per year, including related fees	Covered 100%; no deductible	40%; after deductible
Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible	40%; after deductible
Women's health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%; no deductible	40%; after deductible
Pre-natal maternity	Covered 100%; no deductible	40%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	40%; after deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible	40%; after deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible	Covered 100%; no deductible
Routine eye exams 1 routine exam per 12 months.	$30 office visit copay; no deductible	Not Covered
Routine hearing screening	Covered 100%; no deductible	40%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Office visits to member's selected Primary care physician (PCP)	$30 office visit copay; after deductible	40%; after deductible
Telehealth consultation with non-specialist **CVS Virtual Care**	$30 office visit copay; after deductible $30 office visit copay; after deductible	40%; after deductible 40%; after deductible
Specialist office visits	$50 office visit copay; after deductible	40%; after deductible
Telehealth consultation with specialist	$50 office visit copay; after deductible	40%; after deductible
Hearing exams 1 routine exam per 24 months.	$30 copay; after deductible	40%; after deductible
Walk-in clinics Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	$30 copay; after deductible **Designated Walk-in clinics** Covered 100%; after deductible	40%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Allergy testing		
Primary care physician (PCP)	$30 office visit copay; after deductible	40%; after deductible
Specialist	$50 office visit copay; after deductible	40%; after deductible
Allergy injections	20%; after deductible	40%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Diagnostic X-ray (Other than complex imaging services)	20%; after deductible	40%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic laboratory	20%; after deductible	40%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic complex imaging	20%; after deductible	40%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
EMERGENCY MEDICAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Urgent care provider	20%; after deductible	40%; after deductible
Non-urgent use of urgent care provider	20%; after deductible	Not Covered
Emergency room	20%; after deductible	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	20%; after deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Inpatient coverage	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Inpatient maternity coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Outpatient hospital	20%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - hospital	20%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - freestanding facility	20%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Mental health office visits	$50 copay; after deductible	40%; after deductible
Mental health telehealth consultations	$50 copay; after deductible	40%; after deductible
Other mental health services	Covered 100%; after deductible	40%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
SUBSTANCE ABUSE	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Residential treatment facility	20%; after deductible	40%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Substance abuse office visits	$50 copay; after deductible	40%; after deductible
Substance abuse telehealth consultations	$50 copay; after deductible	40%; after deductible
Other substance abuse services	Covered 100%; after deductible	40%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
THERAPY SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Spinal manipulation therapy	$50 copay; after deductible	40%; after deductible
Outpatient rehabilitative physical and occupational therapy Limited to 60 visits per year Includes physical and occupational therapies.	$50 copay; after deductible	40%; after deductible
Outpatient rehabilitative speech therapy	$50 copay; after deductible	40%; after deductible
Habilitative physical therapy	20%; after deductible	40%; after deductible
Habilitative occupational therapy	20%; after deductible	40%; after deductible
Habilitative speech therapy	20%; after deductible	40%; after deductible
Autism related physical therapy	$50 copay; after deductible	40%; after deductible
Autism related occupational therapy	$50 copay; after deductible	40%; after deductible
Autism related speech therapy	$50 copay; after deductible	40%; after deductible
Autism related behavioral therapy	$50 copay; after deductible	40%; after deductible
These benefits are combined with outpatient mental health visits		
Autism related applied behavior analysis	$50 copay; after deductible	40%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit		

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

OTHER SERVICES	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
***Gender affirming care**		
Primary Care Physician (PCP)	$30 copay; after deductible	40%; after deductible
Specialist Office	$50 copay; after deductible	40%; after deductible
Inpatient Surgery	20%; after deductible	40%; after deductible
Outpatient Hospital Surgery	20%; after deductible	40%; after deductible
Outpatient surgery- freestanding facility	20%; after deductible	40%; after deductible
Skilled nursing facility	20%; after deductible	40%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Home health care	20%; after deductible	40%; after deductible
Private duty nursing not included. Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.		
Hospice care - inpatient	20%; after deductible	40%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Hospice care - outpatient	20%; after deductible	40%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Private duty nursing	20%; after deductible	40%; after deductible
Limited to 70 eight hour shifts per year. We count each period of up to 8 hours as one private duty nursing shift.		
Durable medical equipment	20%; after deductible	40%; after deductible
Infusion therapy - home/office	$50 copay; after deductible	40%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	20%; after deductible	40%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	$50 copay: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
***Hearing aids** Limited to 2 per 3 years up to a max of $2,500	20%; after deductible	40%; after deductible
Transplants	20%; after deductible	40%; after deductible
Bariatric surgery	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		

*Denotes change for 2025

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Acupuncture	20%; after deductible	40%; after deductible
FAMILY PLANNING	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Infertility treatment		
Primary care Physician (PCP)	$30 office visit copay; after deductible	40%; after deductible
Specialist	$50 office visit copay; after deductible	40%; after deductible
You have coverage for artificial insemination and the diagnosis and treatment of the underlying cause of infertility.		
Advanced Reproductive Technology (ART)		
Primary care physician (PCP)	$30 office visit copay; after deductible	40%; after deductible
Specialist	$50 office visit copay; after deductible	40%; after deductible
ART coverage is limited to three cycles per member's lifetime and includes in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Ovulation induction (OI) limited to 3 cycles per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.	40%; after deductible
Tubal ligation	Covered 100%; no deductible	40%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy plan type	Aetna Standard Plan	
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Generic drugs		
Retail	20%	40% of submitted cost; after applicable in-network cost share
Mail order	15%	Not Applicable
Preferred brand-name drugs		
Retail	25% (30 day supply) 20% (31-90 day supply at CVS only)	40% of submitted cost; after applicable in-network cost share
Mail order	20%	Not Applicable
Non-preferred brand-name drugs		
Retail	37.50% 30% (31-90 day supply at CVS only)	40% of submitted cost; after applicable in-network cost share
Mail order	30%	Not Applicable
Specialty drugs		
Preferred specialty	Applicable cost as noted above for generic or brand drugs.	Not Applicable
Non-preferred specialty	Applicable cost as noted above for generic or brand drugs.	Not Applicable
Pharmacy day supply and requirements		
Retail	You can get up to a 90-day supply from Aetna National Network For a 90 day supply you will be responsible for the Mail Order Drug copay. Percentage copays will not be doubled	

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Voluntary maintenance choice mail order	No refill restrictions or penalties apply. Members save when they fill a 90-day supply of maintenance drugs at CVS Caremark® Mail Service Pharmacy or at a CVS Pharmacy.
Specialty	You can get up to a 30-day supply of specialty drugs You must fill all specialty drugs through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List Your medication may be eligible for a $0 copay through PrudentRx. The PrudentRx program is designed to help members save on specialty medications by obtaining copay assistance from drug manufacturers. Here's how it works: When a member is prescribed a specialty medication, PrudentRx will assist them in enrolling in manufacturer copay assistance programs. This process usually takes less than ten minutes but may take up to five to seven days depending on the manufacturer process Once enrolled, members will have a $0 out-of-pocket cost for eligible specialty medications Enrollment in the program begins automatically, but additional steps may be needed. Members can choose to opt-out at any time. PrudentRx can be reached at: 855-476-4118

Your prescription drug plan also includes:
• Diabetic supplies and blood glucose monitors
• Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction

Family planning
• Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).

The following are covered 100% in-network:
• Seasonal vaccinations
• Preventive vaccinations
• Travel vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements
Some covered prescription drugs need approval from us before we will cover the drug.
To get the most up-to-date precertification requirements, see your plan documents or go online to your member website.

GENERAL PROVISIONS

Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.
You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

This amount is based on the out-of-network plan you or your employer picks.
• For doctors and other professionals, the amount is based on the "prevailing" charges. We get this data from an external database.

• For hospitals and other facilities, the amount is based on the Facility Fee Schedule.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

*Denotes change for 2025