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)	None Individual None Family	$4,000 per Individual $8,000 per Family
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. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.		
Member coinsurance Applies to all expenses except as noted.	Covered 100%	You pay 30%
Out-of-pocket limit (per calendar year)	$3,000 per Individual $6,000 per Family	$8,000 per Individual $16,000 per Family
Covered expenses in-network and out -of-network add up towards your in-network and 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 1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	Covered 100%	Covered 100%; deductible waived
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%	Covered 100%; deductible waived
Routine gynecological care exams 2 exam and pap smear per year, includes related fees.	Covered 100%	30%; after deductible

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Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%	30%; 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%	30%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%	30%; after deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%	30%; after deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%	Covered 100%; deductible waived
Routine hearing screening	Covered 100%	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Office visits to member's primary care physician (PCP)	$30 office visit copay	30%; after deductible
Telehealth consultation with non-specialist	$30 office visit copay	30%; after deductible
CVS Virtual Care	No Charge	Not Applicable
Routine eye exams	$30 copay	Not Covered
***Pre-natal Maternity**	$10 copay	30%; after deductible
Specialist office visits This is how much you pay for the services of an internist, general physician, family practitioner, or pediatrician if the physician is not your PCP.	$50 office visit copay	30%; after deductible
Telehealth consultation with specialist This is how much you pay for routine care from an internist, general physician, family practitioner, or pediatrician. Also includes the diagnosis and treatment of an illness or injury.	$50 office visit copay	30%; after deductible
Hearing exams 1 routine exam per 24 months.	$30 office visit copay	30%; 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 **Designated Walk-in clinics** Covered 100%	30%; after deductible
Allergy testing		
Primary Care Physician (PCP)	$30 copay	30%; after deductible
Specialist Office	$50 copay	30%; after deductible
Allergy injections		
Primary Care Physician (PCP)	$30 copay	30%; after deductible
Specialist Office	$50 copay Covered 100% when an office visit charge is not applicable.	30%; after deductible

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DIAGNOSTIC PROCEDURES	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, your cost share is included in the applicable office visit copay.	Covered 100%	30%; after deductible
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%	30%; after deductible
***Diagnostic complex imaging** When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	$75 copay	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Urgent care provider	$75 copay	30%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
***Emergency room** Copay waived if admitted	$200 copay	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	$50 copay	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** When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	$500 copay	30%; after deductible
***Inpatient maternity coverage** (includes delivery and postpartum care) When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	$500 copay	30%; after deductible
Outpatient hospital 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, unless otherwise noted.	Covered 100%	30%; after deductible
***Outpatient surgery - hospital** 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.	$350 copay	30%; after deductible
Outpatient surgery - freestanding facility 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.	$200 copay	30%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
***Inpatient** When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	$500 copay	30%; after deductible
***Mental health office visits**	$20 copay	30%; after deductible
***Mental health telehealth consultations**	$20 copay	30%; after deductible
Other mental health services	Covered 100%	30%; after deductible

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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**	$500 copay	30%; 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**	$500 copay	30%; 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**	$20 copay	30%; after deductible
***Substance abuse telehealth consultations**	$20 copay	30%; after deductible
Other substance abuse services	Covered 100%	30%; 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**	$10 copay	30%; after deductible
Speech Therapy	$50 copay	30%; after deductible
***Outpatient short-term Physical Therapy**	$20 copay	30%; after deductible
***Occupational Therapy**	$20 copay	
Limited to 60 visits per year Includes physical and occupational therapies.		
Habilitative physical therapy	Covered 100%	30%; after deductible
Habilitative occupational therapy	Covered 100%	30%; after deductible
Habilitative speech therapy	Covered 100%	30%; after deductible
Autism related physical therapy	Covered 100%	30%; after deductible
Autism related occupational therapy	Covered 100%	30%; after deductible
Autism related speech therapy	Covered 100%	30%; after deductible
Autism related behavioral therapy	Covered 100%	30%; after deductible
These benefits are combined with outpatient mental health visits		
Autism related applied behavior analysis	Covered 100%	30%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit		

OTHER SERVICES	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
***Gender affirming care**		
Primary Care Physician (PCP)	$30 copay	30%; after deductible
Specialist Office	$50 copay	30%; after deductible
Inpatient Surgery	$500 copay	30%; after deductible
Outpatient Hospital Surgery	$350 copay	30%; after deductible
Outpatient surgery- freestanding facility	$200 copay	30%; after deductible
***Skilled nursing facility**	$500 copay	30%; 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	Covered 100%	30%; after deductible
Home health care services excluded private duty nursing		

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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	Covered 100%	30%; 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	Covered 100%	30%; 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	$50 copay	30%; after deductible
Limited to 70 - 8 hour shifts		
We count each period of up to 8 hours as one private duty nursing shift.		
***Durable medical equipment**	20%	30%; after deductible
Infusion therapy - home/office		
Home	Covered 100%	30%; after deductible
Primary care physician	$30 copay	30%; after deductible
Specialist office	$50 copay	30%; after deductible
Infusion therapy		
Home	Covered 100%	30%; after deductible
Primary care physician	$30 copay	30%; after deductible
Specialist office	$50 copay	30%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	$50 copay In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
***Transplants**	$500 copay	30%; after deductible
***Hearing aids** Limited to 2 per 3 years up to a max of $2,500	Covered 100%	30%; after deductible
***Bariatric surgery**	$500 copay	30%; after deductible
Acupuncture	$50 copay	30%; after deductible
FAMILY PLANNING	**IN-NETWORK DESIGNATED PROVIDERS**	**OUT-OF-NETWORK**
Infertility treatment		
Primary Care Physician	$30 copay	30%; after deductible
Specialist	$50 copay	30%; 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	$30 copay	30%; after deductible
Specialist	$50 copay	30%; after deductible
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), ovulation induction (OI), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery. Limited to 3 cycles per lifetime		
Vasectomy	Covered 100%	30%; after deductible
Tubal ligation	Covered 100%	30%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy plan type	Aetna Standard Plan	

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Prescription Drug Deductible (per calendar year)	$75 per Individual $150 per Family	$75 per Individual $150 per Family
Covered prescription drug expenses add up toward both your in-network and out-of-network prescription drug deductible at the same time. You must first meet the prescription drug deductible before the plan begins paying prescription drug benefits, unless otherwise noted. Your family will have one prescription drug deductible. You will meet it when the expenses of several family members add up to the family prescription drug deductible. No one person will have to pay more than the individual prescription drug deductible.		
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Covered prescription drug expenses add up toward both your in-network and out-of-network prescription drug out-of-pocket limit at the same time.		
Generic drugs		
Retail	15%	30% 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)	30% of submitted cost; after applicable in-network cost share
Mail order	20%	Not Applicable
Non-preferred brand-name drugs		
Retail	37.5% (30 day supply) 20% (31-90 day supply at CVS only)	30% 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	
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.	

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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

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.
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.

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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.

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The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.
• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.