Anne Arundel County
Open Choice PPO

Anne Arundel County
Effective Date: 01-01-2022
Open Choice® PPO

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated.		
Deductible (per calendar year)	$125 Individual $250 Family	$500 Individual $1,000 Family
All covered expenses, accumulate toward the in-network and out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. Pharmacy benefits are offered through CVS Caremark. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance	5%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$500 Individual $1,000 Family	$1,500 Individual $3,000 Family
All covered expenses accumulate toward the in-network and out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required.		
Referral Requirement	None	None

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PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations 1 exam per calendar year	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	30%; after deductible
Routine Mammograms	Covered 100%; deductible waived	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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	30%; after deductible
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	30%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	30%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived	30%; after deductible
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible

PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$15 office visit copay; deductible waived	30%; after deductible
Telemedicine Consultation with Non-Specialist	$15 office visit copay; deductible waived	30%; after deductible
Specialist Office Visits	$35 office visit copay; deductible waived	30%; after deductible
Telemedicine Consultation with Specialist	$35 office visit copay; deductible waived	30%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.	**Designated Walk-in Clinics** Covered 100%; deductible waived **All Other Network Providers** $15 copay; deductible waived	30%; after deductible

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Telemedicine Consultations for Non-Emergency Services through a Walk-in Clinic	Your cost sharing is based on the type of service and where it is performed **Designated Walk-in Clinics** Covered 100%; deductible waived	30%; after deductible
If telemedicine preventive screening and counseling services are provided through a walk-in clinic, these services are paid under the preventive care benefit.		
Allergy Testing	5% after deductible	30%; after deductible
Allergy Injections	$15 Non-Specialist or $35 Specialist	30%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Laboratory	5% after deductible	5% after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory at Independent Lab	Covered 100%; deductible waived	Not Covered
Diagnostic X-ray (other than Complex Imaging Services)	5% after deductible	5% after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Freestanding Radiology Centers	Covered 100%; deductible waived	N/A
Diagnostic Complex Imaging	5% after deductible	5% after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$35 office visit copay; deductible waived	$35 office visit copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$75 copay; deductible waived	$75 copay; deductible waived
Emergency Use of Ambulance	Covered 100%; deductible waived	Covered 100%; deductible waived
Non-Emergency Use of Ambulance	Covered 100%; deductible waived	Covered 100%; deductible waived
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	5%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	5%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	5%; after deductible	30%; after deductible
Outpatient Professional Expenses	$15 PCP copay/$35 specialist copay	30%; after deductible
Outpatient Surgery - Hospital	5%; after deductible	30%; after deductible
Outpatient Professional Expenses	$15 PCP copay/$35 specialist copay	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Outpatient Surgery - Freestanding Facility	5%; after deductible	30%; after deductible
Outpatient Professional Expenses	$15 PCP copay/$35 specialist copay	30%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	5%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$15 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Mental Health Telemedicine Consultations	$15 office visit copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	5%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	5%; after deductible	30%; after deductible
Substance Abuse Office Visits	$15 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Substance Abuse Telemedicine Consultations	$15 office visit copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	5%; after deductible Unlimited days	30%; after deductible Limited to 120 days per year
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; deductible waived	Covered 100%; deductible waived
Home health care services include outpatient private duty nursing Limited to 3 intermittent visits per day by a home health care agency; 1 visit equals a period of 4 hours or less.		
Hospice Care - Inpatient	Covered 100%; deductible waived	Covered 100%; deductible waived
Hospice Care - Outpatient	Covered 100%; deductible waived	Covered 100%; deductible waived
Chiropractic Services - Spinal Manipulation Therapy	$35 copay; deductible waived	30%; after deductible
Outpatient Short-Term Rehabilitation Limited to 300 visits per year Includes speech, physical, occupational therapy	$35 copay; deductible waived	30%; after deductible
Habilitative Physical Therapy	Covered 100%; deductible waived	30%; after deductible
Habilitative Occupational Therapy	Covered 100%; deductible waived	30%; after deductible
Habilitative Speech Therapy	Covered 100%; deductible waived	30%; after deductible
Autism Behavioral Therapy	$15 copay; deductible waived	30%; after deductible

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Autism Applied Behavior Analysis	Covered 100%; deductible waived	30%; after deductible
Autism Physical Therapy	Covered 100%; deductible waived	30%; after deductible
Autism Occupational Therapy	Covered 100%; deductible waived	30%; after deductible
Autism Speech Therapy	Covered 100%; deductible waived	30%; after deductible
Durable Medical Equipment	5%; after deductible	5%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered 100%; deductible waived	Covered 100%; deductible waived
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	30%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	30%; after deductible
Infusion Therapy Administered in the home, physician's office, outpatient hospital or freestanding facility	5%; after deductible	5%; after deductible
Transplants	5%; after deductible	30%; after deductible
Bariatric Surgery	5%; after deductible	30%; after deductible
Hearing Aids	Covered 100%; deductible waived	Covered 100%; deductible waived
Limited to 2 hearing aids every 36 months, $1,400 maximum per hearing aid		
Acupuncture	$35 copay; deductible waived	30%; after deductible
Gender Reassignment Services/Surgery	Your cost sharing is based on the type of service and where it is performed	
Vision Eyewear	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services	Your cost sharing is based on the type of service and where it is performed	
Coverage includes Artificial Insemination, limited to six (6) attempts per live birth.		
In-vitro fertilization	Your cost sharing is based on the type of service and where it is performed	
Limited to three (3) attempts per live birth and $100,000 lifetime maximum.		
Vasectomy	100%; deductible waived	100%; deductible waived
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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 received 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.

Plans are provided by Aetna Life Insurance Company. 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.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Surgical removal of impacted teeth
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including 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 the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
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.