aetna

# Anne Arundel County
# Open Choice PPO

Anne Arundel County, Maryland
Effective Date: 01-01-2025
Open Choice® PPO

**PLAN DESIGN & BENEFITS**
**ADMINISTERED BY AETNA LIFE 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<br>$250 Family | $500 Individual<br>$1,000 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.<br>You must first meet the deductible before the plan begins paying benefits, unless otherwise noted.<br>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. Pharmacy benefits are offered through CVS Caremark. Refer to your plan documents for details.<br>The family deductible is a cumulative deductible for all family members. 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**<br>Applies to all expenses except as noted. | You pay 5% | You pay 30% |
| **Out-of-pocket limit** (per calendar year) | $500 Individual<br>$1,000 Family | $1,500 Individual<br>$3,000 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.<br>Some of your cost sharing may not count toward the out-of-pocket limit.<br>Your pharmacy expenses do not count toward your out-of-pocket limit.<br>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 out-of-pocket limit.<br>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**<br>Unlimited except where otherwise indicated. | | |
| **Primary care physician selection** | Optional | Not Applicable |
| **Precertification requirements -**<br>Some out-of-network services need approval by us in advance (precertification). 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 |
| **PREVENTIVE CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Routine adult physical exams/ immunizations**<br>1 exam per calendar year | Covered 100%; no deductible | 30%; after deductible |
| **Routine well child exams/immunizations**<br>• 7 exams in the first 12 months<br>• 3 exams from age 13 to 24 months<br>• 3 exams from age 25 to 36 months<br>• 1 exam per calendar year thereafter until age 22 | Covered 100%; no deductible | 30%; after deductible |
| **Routine gynecological care exams**<br>1 exam and pap smear per year, includes related fees. | Covered 100%; no deductible | 30%; after deductible |
| **Routine mammogram**<br>Recommended: One per year for members age 40 and over | Covered 100%; no deductible | 30%; after deductible |

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| **Women's health** | Covered 100%; no deductible | 30%; after deductible |
| 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.<br>Contraceptive methods, sterilization procedures, patient education, and counseling. Limitations may apply | | |
| **Pre-natal maternity** | Covered 100%; no deductible | 30%; after deductible |
| **Routine digital rectal exam** | Covered 100%; no deductible | 30%; after deductible |
| Recommended: For covered males 40 and over | | |
| **Prostate-specific antigen test** | Covered 100%; no deductible | 30%; after deductible |
| Recommended: For covered males 40 and over | | |
| **Colorectal cancer screening** | Covered 100%; no deductible | 30%; after deductible |
| Recommended: For members age 45 and over | | |
| **Routine eye exams** | Not Covered | Not Covered |
| **Routine hearing screening** | Covered 100%; no deductible | 30%; after deductible |

| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
|---|---|---|
| **Office visits to non-specialist** | $15 office visit copay; no deductible | 30%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Telemedicine Consultation with non-Specialist** | $15 office visit copay; no deductible | 30%; after deductible |
| **Specialist office visits** | $35 office visit copay; no deductible | 30%; after deductible |
| **Hearing exams** | Not Covered | Not Covered |
| **Walk-in clinics** | $15 copay; no deductible<br>**Designated Walk-in clinics**<br>Covered 100%; no deductible | 30%; after deductible |
| 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.<br>Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. | | |
| **Telehealth consultations for non-emergency services through a walk-in clinic** | Your cost sharing amount depends on the type of service and where you receive it.<br>**Designated Walk-in clinics**<br>Covered 100%; no deductible | 30%; after deductible |
| We pay telehealth screenings and counseling services from a walk-in-clinic as a 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 X-ray** (Other than complex imaging services) | 5%; after deductible | 5%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | | |
| **Diagnostic laboratory** | 5%; after deductible | 5%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | | |
| **Diagnostic laboratory at independent lab** | Covered 100%; no deductible | 5%; after deductible |

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| **Diagnostic complex imaging** | 5%; after deductible | 5%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | | |
| **Freestanding Radiology Centers** | Covered 100%; no deductible | N/A |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Urgent care provider** | $35 office visit copay; no deductible | $35 office visit copay; no deductible |
| **Non-urgent use of urgent care provider** | Not Covered | Not Covered |
| **Emergency room** | $75 copay; no deductible | $75 copay; deductible waived |
| Copay waived if admitted | | |
| **Emergency use of ambulance** | Covered 100%; no deductible | Covered 100%; no deductible |
| **Non-emergency use of ambulance** | Covered 100%; no deductible | Covered 100%; no deductible |
| **HOSPITAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient coverage** | 5%; after deductible | 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. | | |
| **Inpatient maternity coverage** (includes delivery and postpartum care) | 5%; after deductible | 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. | | |
| **Outpatient hospital** | 5%; after deductible | 30%; after deductible |
| Outpatient Professional Expenses | $15 PCP/$35 specialist copay | 30%; after deductible |
| **Outpatient surgery - hospital** | 5%; after deductible | 30%; after deductible |
| Outpatient Professional Expenses | $15 PCP/$35 specialist copay | 30%; after deductible |
| **Outpatient surgery - freestanding facility** | 5%; after deductible | 30%; after deductible |
| Outpatient Professional Expenses | $15 PCP/$35 specialist copay | 30%; after deductible |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 5%; after deductible | 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. | | |
| **Mental health office visits** | $15 copay; no deductible | 30%; after deductible |
| **Mental health telemedicine consultations** | $15 copay; no deductible | 30%; after deductible |
| **Other mental health services** | Covered 100%; no deductible | 30%; after deductible |
| **SUBSTANCE ABUSE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 5%; after deductible | 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** | 5%; after deductible | 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. | | |

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| **Substance abuse office visits** | $15 copay; no deductible | 30%; after deductible |
| **Substance abuse telemedicine consultations** | $15 copay; no deductible | 30%; after deductible |
| **Other substance abuse services** | Covered 100%; no deductible | 30%; after deductible |
| **THERAPY SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Spinal manipulation therapy** | $35 copay; no deductible | 30%; after deductible |
| **Outpatient short-term rehabilitation**<br>Limited to 300 visits per year<br>Includes physical, occupational, and speech therapies. | $35 copay; no deductible | 30%; after deductible |
| **Habilitative physical therapy** | Covered 100%; no deductible | 30%; after deductible |
| **Habilitative occupational therapy** | Covered 100%; no deductible | 30%; after deductible |
| **Habilitative speech therapy** | Covered 100%; no deductible | 30%; after deductible |
| **Autism related physical therapy** | Covered 100%; no deductible | 30%; after deductible |
| **Autism related occupational therapy** | Covered 100%; no deductible | 30%; after deductible |
| **Autism related speech therapy** | Covered 100%; no deductible | 30%; after deductible |
| **Autism related behavioral therapy**<br>These benefits are combined with outpatient mental health visits | $15 copay; no deductible | 30%; after deductible |
| **Autism related applied behavior analysis**<br>Your benefits for these services are the same as any other outpatient mental health other services benefit | Covered 100%; no deductible | 30%; after deductible |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled nursing facility**<br><br>When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive. | 5%; after deductible<br>Unlimited days | 30%; after deductible<br>Limited to 120 days per year |
| **Home health care**<br><br>Home health care services include private duty nursing<br>Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less. | Covered 100%; deductible waived | Covered 100%; deductible waived |
| **Hospice care - inpatient**<br>When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive. | Covered 100%; deductible waived | Covered 100%; deductible waived |
| **Hospice care - outpatient**<br>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. | Covered 100%; deductible waived | Covered 100%; deductible waived |
| **Private duty nursing**<br>We count each period of up to 8 hours as one private duty nursing shift. | Covered as part of home health care | Covered as part of home health care |

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| **Durable medical equipment** | 5%; no deductible | 5%; no deductible |
| **Diabetic supplies** -- (if not covered under the prescription drug benefit) | Covered 100%; no deductible | Covered 100%; no deductible |
| **Affordable Care Act Mandated Women's Contraceptives** | Covered 100%; no deductible | 30%; after deductible |
| **Women's Contraceptive drugs and devices not obtainable at a pharmacy** | Covered 100%; no deductible | 30%; after deductible |
| **Infusion therapy - home/office** | 5%; after deductible | 5%; after deductible |
| **Infusion therapy - outpatient hospital/freestanding facility** | 5%; after deductible | 5%; after deductible |
| **Transplants** | 5%; after deductible<br>In-network coverage is only available at Institutes of Excellence (IOE) contracted facility. | 30%; after deductible<br>Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility. |
| **Bariatric surgery** | 5%; after deductible | 30%; after deductible |
| **Hearing Aids**<br>Limited to 2 hearing aids every 36 months, $1,400 maximum per hearing aid | Covered 100%; no deductible | Covered 100%; no deductible |
| **Vision Eyewear** | Not Covered | Not Covered |
| **Gender Reassignment Services/Surgery** | Your cost sharing is based on the type of service and where it is performed | |
| **Acupuncture** | $35 copay; no deductible | 30%; after deductible |
| **FAMILY PLANNING** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Infertility treatment**<br>You have coverage for artificial insemination (6 attempts per live birth), IUI, and the diagnosis and treatment of the underlying cause of infertility. | Your cost sharing amount depends on the type of service and where you receive it. | Your cost sharing amount depends on the type of service and where you receive it. |
| **Advanced Reproductive Technology (ART)**<br>In-vitro fertilization (3 attempts per live birth up to $100,000 lifetime maximum), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), ovulation induction (OI), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery | Your cost sharing amount depends on the type of service and where you receive it. | Your cost sharing amount depends on the type of service and where you receive it. |
| **Vasectomy** | 100%; no deductible | 100%; no deductible |
| **Tubal ligation** | Covered 100%; no deductible | 30%; after deductible |
| **GENERAL PROVISIONS** | | |
| **Dependents who are eligible to be on your plan** | Spouse, children from birth through the end of the month in which they turn 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.

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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.

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.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• 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.