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Anne Arundel County
Open Access Aetna Select HMO/EPO

Anne Arundel County, Maryland
Effective Date: 01-01-2025
Aetna Open Access® Aetna Select℠

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

PLAN FEATURES	IN-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)	$100 Individual $200 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. Pharmacy benefits are offered through CVS Caremark. 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 Applies to all expenses except as noted.	Covered 100%
Out-of-pocket limit (per calendar year)	$1,100 Individual $3,600 Family
Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses do not count toward your out-of-pocket limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except penalty amounts) may be used to satisfy the out-of-pocket limit. 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.	
Primary care physician selection	Optional
Referral requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine adult physical exams/ immunizations 1 exam every calendar year	Covered 100%; no deductible
Routine well child exams/immunizations • 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 calendar year thereafter to age 22	Covered 100%; no deductible
Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible
Routine mammogram	Covered 100%; no 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

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Pre-natal maternity	Covered 100%; no deductible
Routine digital rectal exam Recommended: For covered males age 40 and over	Covered 100%; no deductible
Prostate-specific antigen test Recommended: For covered males age 40 and over	Covered 100%; no deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible
Routine eye exams	Not Covered
Routine hearing screening	Covered 100%; no deductible
PHYSICIAN SERVICES	**IN-NETWORK**
Office visits to primary care physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician.	$15 office visit copay; no deductible
Telemedicine Consultation with non-Specialist	$15 office visit copay; no deductible
Specialist office visits	$15 office visit copay; no deductible
Telemedicine Consultation with Specialist	$15 office visit copay; no deductible
Hearing exams	Not Covered
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.	$15 copay; no deductible **Designated Walk-in clinics** Covered 100%; no deductible
Telehealth consultations for non-emergency services through a walk-in clinic We pay telehealth screenings and counseling services from a walk-in-clinic as a preventive care benefit.	Your cost sharing amount depends on the type of service and where you receive it. **Designated Walk-in clinics** Covered 100%; no deductible
Allergy testing	$15 copay
Allergy injections	$15 copay
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%; no 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%; no deductible
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%; no deductible

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EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent care provider	$35 office visit copay; no deductible
Non-urgent use of urgent care provider	Not Covered
Emergency room Copay waived if admitted	$75 copay; no deductible
Emergency use of ambulance	Covered 100%; no deductible
Non-emergency use of ambulance	Covered 100%; no deductible
HOSPITAL CARE	**IN-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.	Covered 100%; 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.	Covered 100%; after deductible
Outpatient hospital Outpatient Professional Expenses	$25 copay; no deductible $15 copay; no deductible
Outpatient surgery - hospital Outpatient Professional Expenses	$25 copay; no deductible $15 copay; no deductible
Outpatient surgery - freestanding facility Outpatient Professional Expenses	$25 copay; no deductible $15 copay; no deductible
MENTAL HEALTH SERVICES	**IN-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.	Covered 100%; after deductible
Mental health office visits	$15 copay; no deductible
Mental health telemedicine consultations	$15 copay; no deductible
Other mental health services	Covered 100%; no deductible
SUBSTANCE ABUSE	**IN-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.	Covered 100%; after deductible
Residential treatment facility 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%; after deductible
Substance abuse office visits	$15 copay; no deductible
Substance abuse telemedicine consultations	$15 copay; no deductible
Other substance abuse services	Covered 100%; no deductible
THERAPY SERVICES	**IN-NETWORK**
Spinal manipulation therapy*	$15 copay; no deductible

Coverage dependent on periodic review for medical necessity

Outpatient short-term rehabilitation*	$15 copay; no deductible
Limited to 150 visits per year, Includes physical, occupational, and speech therapies.	
Habilitative physical therapy*	Covered 100%; no deductible
Habilitative occupational therapy*	Covered 100%; no deductible
Habilitative speech therapy*	Covered 100%; no deductible
Autism related physical therapy*	Covered 100%; no deductible
Autism related occupational therapy*	Covered 100%; no deductible
Autism related speech therapy*	Covered 100%; no deductible
Autism related behavioral therapy	$15 copay; no deductible
These benefits are combined with outpatient mental health visits	
Autism related applied behavior analysis	Covered 100%; no deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit	
OTHER SERVICES	**IN-NETWORK**
Skilled nursing facility*	Covered 100%; after deductible
Limited to 120 days per year 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%; after deductible
Home health care services include private duty nursing 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%; deductible waived
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%; deductible waived
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.	
Durable medical equipment	Covered 100%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered 100%; deductible waived
Infusion therapy - home/office	Covered 100%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	Covered 100%; after deductible
Transplants	Covered 100%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.

***Coverage dependent on periodic review for medical necessity**

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Bariatric surgery	Your cost sharing is based on the type of service and where it is performed
Gender Reassignment Services/Surgery	Your cost sharing is based on the type of service and where it is performed
Hearing Aids	Covered 100%; no deductible
Limited to 2 hearing aids every 36 months, maximum of $1,400 per hearing aid	
Vision Eyewear	Not Covered
Acupuncture	$15 copay; no deductible
Limited to 50 visits per year	

FAMILY PLANNING	**IN-NETWORK**
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for artificial insemination (6 attempts per live birth), IUI, and the diagnosis and treatment of the underlying cause of infertility.	
Advanced Reproductive Technology (ART)	Your cost sharing amount depends on the type of service and where you receive it.
In-vitro fertilization (3 attempts per live birth up to $100,000 lifetime max), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), ovulation induction (OI), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
Vasectomy	Covered 100%; no deductible
Tubal ligation	Covered 100%; no 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.

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.