The Arc of Washington County, Inc.
Effective Date: 01-01-2023
Aetna Open Access® Aetna Select℠
Network Services Only

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA HEALTH 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. Refer to your plan documents for more information.	
Deductible (per calendar year)	$2,000 Individual $4,000 Family
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. 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	10%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$7,350 Individual $14,700 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses 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
Referral Requirement	None
Telemedicine Consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com/ to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.	
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	
Routine Gynecological Care Exams	Covered 100%; deductible waived
1 exam and pap smear per year, includes related fees.	
Routine Mammograms	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived
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.	
Routine Digital Rectal Exam	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	

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Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%; deductible waived
Routine Hearing Screening	Covered 100%; deductible waived
Medications	Certain over-the-counter preventive medications covered 100% in network.
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	$25 office visit copay; deductible waived
Telemedicine Consultation with Non-Specialist	$25 office visit copay; deductible waived
Specialist Office Visits	$50 office visit copay; deductible waived
Telemedicine Consultation with Specialist	$50 office visit copay; deductible waived
Hearing Exams 1 routine exam per 24 months.	$50 copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$25 copay; deductible waived **Designated Walk-in Clinics** Covered 100%; deductible waived
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.	
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
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	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray 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.	10%; after deductible
Diagnostic Laboratory 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.	10%; after deductible
Diagnostic Complex Imaging 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.	10%; after deductible

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EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent Care Provider	10%; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	10%; after deductible
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	10%; after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	10%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Hospital	10%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Freestanding Facility	10%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$50 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Mental Health Telemedicine Consultations	$50 office visit copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	10%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	10%; after deductible
Substance Abuse Office Visits	$50 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Substance Abuse Telemedicine Consultations	$50 office visit copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	10%; after deductible

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OTHER SERVICES	IN-NETWORK
Skilled Nursing Facility Limited to 100 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible
Home Health Care Limited to 60 visits per year Private Duty Nursing not covered Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	Covered 100%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible
Private Duty Nursing	Not Covered
Outpatient Short-Term Rehabilitation Limited to 60 visits per year Includes speech, physical, occupational therapy	$50 copay; after deductible
Spinal Manipulation Therapy Limited to 100 visits per year	$50 copay; after deductible
Habilitative Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health All Other benefit	Refer to MBH Outpatient Mental Health All Other
Autism Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	10%; after deductible
Orthotics	10%; after deductible
Hearing Aids Limited to $2,800 every 36 months to age 18.	10%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	$50 copay; deductible waived
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	10%; after deductible
Gene-based, Cellular, and other Innovative Therapies™ (GCIT)	Your cost sharing is based on the type of service and where it is performed $50 copay; deductible waived for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.

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Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Not Covered
Acupuncture Limited to 10 visits per year.	$25 copay; deductible waived
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	Applicable cost sharing based on the type of service performed and place of service where rendered
Diagnosis and treatment of the underlying medical condition only.	
Comprehensive Infertility Services	10%; after deductible
Artificial insemination and ovulation induction. Limited to $25,000 in member's lifetime combined with Advanced Reproductive Technology. Maximum applies to all procedures covered by any of our plans except where prohibited by law.	
Advanced Reproductive Technology (ART)	10%; after deductible
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery. Covered only after 2 years of infertility. Limited to $25,000 in member's lifetime combined with Comprehensive Infertility. Maximum applies to all procedures covered by any of our plans except where prohibited by law.	
Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived
GENERAL PROVISIONS	
Dependents Eligibility - Spouse, children from birth to age 26 regardless of student status.	

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.
• Hearing aids
• 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.