NEW CASTLE COUNTY
Effective Date: 01-01-2027
Aetna Open Access® Aetna Select℠

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

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	$2,500 Individual $5,000 Family
Member Coinsurance Applies to all expenses unless otherwise stated.	100%
Payment Limit (per calendar year) Certain member cost sharing elements may not apply toward 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.	$8,700 Individual $17,400 Family
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 12 months up to age 65, 1 exam every 12 months age 65 and older	100%; no deductible
Routine Well Child Exams 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year after age 3 to age 18	100%; no deductible Covered 100%, for Immunizations
Routine Gynecological Care Exams Recommended: One exam per calendar year. Includes routine tests and related lab fees.	100%; no deductible
Routine Mammograms Recommended: One annual mammogram for covered females age 40 and over.	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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	100%; no deductible
Routine Digital Rectal Exam	100%; no deductible
Prostate-specific Antigen Test	100%; no deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over	100%; no deductible
Routine Eye Exams	$35 copay; after deductible, 1 exam every 24 months
Vision Eyewear	100% up to $100 every 24 months
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Office Visits Includes services of an internist, general physician, family practitioner or pediatrician.	$25 copay; after deductible

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Specialist Office Visits	$35 copay; after deductible
Walk-in clinic visits	$25 copay; after deductible
Hearing Exam 1 exam in any 24 consecutive month period	$35 copay; after deductible
Pre-Natal Maternity	100%; after deductible
Allergy Testing	$25 copay; after deductible
Allergy Injections	$25 copay; after deductible

DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	100%; 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	100%; 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 Complex Imaging	100%; after deductible

EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$25 copay; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$100 copay; after deductible Copay waived if admitted
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	100%; after deductible
Non-Emergency Use of Ambulance	Not Covered

HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	100%; after deductible
Inpatient Maternity Coverage (includes delivery / postpartum care)	100%; after deductible
Outpatient Hospital	100%; after deductible
Outpatient Surgery - Hospital	100%; after deductible
Outpatient Surgery - Freestanding Facility	100%; after deductible

MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	100%; after deductible
Outpatient	100%; after deductible

ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**
Inpatient	100%; after deductible
Residential Treatment Facility	100%; after deductible
Outpatient	100%; after deductible
Home Health Care	100%; after deductible

Limited to 100 visits per calendar year.
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.

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Hospice Care - Inpatient	100%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Hospice Care - Outpatient	100%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Private Duty Nursing	100%; after deductible
Outpatient Short-Term Rehabilitation Limited to 60 visits per calendar year. Speech, Physical and Occupational.	100%; after deductible
Spinal Manipulation Therapy Limited to 30 visits per calendar year.	100%; after deductible
Autism Behavioral Therapy	100%; after deductible
Autism Applied Behavior Analysis	100%; after deductible
Autism Physical Therapy	100%; after deductible
Autism Occupational Therapy	100%; after deductible
Autism Speech Therapy	100%; after deductible
Durable Medical Equipment	100%; after deductible
Hearing Aids One per ear every 36 month	100%; after deductible
Diabetic Supplies	100%; after deductible
Generic FDA-approved Women's Contraceptives	100%; no deductible
Contraceptive drugs and devices not obtainable at a pharmacy	100%; no deductible
Transplants	100%; after deductible
Preferred coverage is provided at an IOE contracted facility only.	
Bariatric Surgery	100%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	

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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.	
Comprehensive Infertility Services	Applicable cost sharing based on the type of service performed and place of service where rendered
Coverage includes Artificial Insemination and Ovulation Induction. Maximum $40,000 per lifetime combined for AI/OI and ART.	
Advanced Reproductive Technology (ART)	Applicable cost sharing based on the type of service performed and place of service where rendered %
ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Maximum $40,000 per lifetime combined for AI/OI and ART. Limited to 6 completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer (SET) when recommended and medically appropriate.	
Vasectomy	100%; no deductible
Tubal Ligation	100%; no deductible

Prescription Drug

RX Benefits/Express Scripts manages the prescription-drug benefits for NEW CASTLE COUNTY employees. Your Pharmacy benefit includes:

- Access to Member Services at 1-800-334-8134 or customerare@rxbenefits.com 7am-8pm, Mon-Fri.
- Use a Retail pharmacy or Home Delivery from the Express Scripts Pharmacy℠ for your maintenance medications for the same copayment amount.

Copayments for Your Prescription-Drug Program

Prescriptions from a Participating Retail Pharmacy (up to a 30 day supply)	Participating Retail Pharmacy or Express Scripts Pharmacy (Home Delivery) (up to a 90 day supply)
Generic medication: $8	Generic medication: $16
Preferred brand-name medication: $30	Preferred brand-name medication: $60
Non-preferred brand-name medication: $50	Non-preferred brand-name medication: $100
Out-of-pocket Maximum – combined with Medical: $8,700 Individual $17,400 Family	

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GENERAL PROVISIONS

Dependents Eligibility - Spouse, children from birth to age 26 regardless of student status.

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.

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.

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.
• 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.
• 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 or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Therapy or rehabilitation other than those listed as covered.•

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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 **1-855-281-8858.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-855-281-8858.**

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

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional.

For more information about Aetna plans, refer to **www.aetna.com.**

For self-funded plans, coverage is offered by your employer and administrative services are provided by Aetna Life Insurance Company (Aetna).

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