



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

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	\$300 Individual

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.

Member Coinsurance	20%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	\$1,500 Individual \$3,000 Family

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
Referral Requirement	None

PREVENTIVE CARE	IN-NETWORK
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Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
Routine Well Child Exams	Covered 100%; deductible waived
Routine Gynecological Care Exams	Covered 100%; deductible waived
Recommended: One exam per calendar year. Includes routine tests and related lab fees.	
Routine Mammograms	Covered 100%; deductible waived
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
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.	
Prostate-specific Antigen Test	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 50 and over.	
Routine Eye Exams	Covered 100%; deductible waived
1 routine exam per 24 months.	
Routine Hearing Screening	Covered 100%; deductible waived



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PHYSICIAN SERVICES	IN-NETWORK
Primary Care Physician Visits	\$15 copay; deductible waived
Specialist Office Visits	\$30 copay; deductible waived
Audiometric Hearing Exam	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	\$15 copay; deductible waived
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	IN-NETWORK
Diagnostic X-ray	Covered 100%; deductible waived
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	Covered 100%; deductible waived
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	20%; after deductible at Hospital; \$30 copay; <u>deductible waived</u> at Freestanding Facility
EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent Care Provider	\$30 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	\$250 copay; deductible waived
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%; deductible waived
Non-Emergency but Medically Necessary Use of Ambulance	Covered 100%; deductible waived
HOSPITAL CARE	IN-NETWORK
Inpatient Coverage	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Maternity Coverage	20%; after deductible
(includes delivery and postpartum care –no separate office copay for postnatal) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Hospital	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Hospital	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	



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Outpatient Surgery - Freestanding Facility	\$100 copay; deductible waived
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
MENTAL HEALTH SERVICES	IN-NETWORK
Inpatient	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient	\$30 copay; deductible waived
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
ALCOHOL/DRUG ABUSE SERVICES	IN-NETWORK
Inpatient	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Residential Treatment Facility	20%; after deductible
Outpatient	\$30 copay; deductible waived
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
OTHER SERVICES	IN-NETWORK
Convalescent Facility	\$25 copay per day for the first 5 days per admission, deductible waived, thereafter covered 100% deductible waived.
Limited to 30 days per calendar year.	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Home Health Care	Covered 100%; deductible waived
Limited to 60 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.	
Hospice Care - Inpatient	Not Covered
Hospice Care - Outpatient	Not Covered
Private Duty Nursing	Not Covered
Outpatient Short-Term Rehabilitation	\$30 copay; deductible waived
Limited to 60 visits per calendar year combined.	
Spinal Manipulation Therapy	\$15 PCP/\$30 Specialist copay; deductible waived
Limited to 20 days per calendar year.	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits	
Autism Applied Behavior Analysis	\$30 copay; deductible waived
Autism Physical Therapy	\$30 copay; deductible waived
Autism Occupational Therapy	\$30 copay; deductible waived
Autism Speech Therapy	\$30 copay; deductible waived
Durable Medical Equipment (Includes Hearing Aids - \$300 /12 mos)	Covered 100%; deductible waived
Prosthetics	Covered 100%; deductible waived
Orthotics	Covered 100%; deductible waived



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Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered 100%; deductible waived
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%; after deductible
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 an underlying medical condition will be covered.	
Comprehensive Infertility Services	Not Covered
Advanced Reproductive Technology (ART)	Not Covered
Vasectomy	Not Covered
Tubal Ligation	Covered 100%; deductible waived
PHARMACY	IN-NETWORK
Pharmacy Plan Type	Aetna Standard Formulary
Pharmacy Maximum \$5,000 / Individual \$10,000 / Family	
Retail	\$10 copay for formulary generic drugs ; \$50 copay for formulary brand-name drugs; \$75 copay for non-formulary brand-name and non-formulary generic drugs up to a 30 day supply at participating pharmacies.
Mail Order	\$10 copay for formulary generic drugs ; \$50 copay for formulary brand-name drugs; \$75 copay for non-formulary brand-name and non-formulary generic drugs. Up to a 31-90 day supply from Aetna Rx Home Delivery®.
Standard Specialty Drugs	\$10 copay for formulary generic drugs ; \$50 copay for formulary brand-name drugs; \$75 copay for non-formulary brand-name and non-formulary generic drugs Up to a 30 day supply from Aetna Specialty Pharmacy Network.
CVS Maintenance Choice (90) Day Supply at Retail	\$10 copay for formulary generic drugs ; \$50 copay for formulary brand-name drugs; \$75 copay for non-formulary brand-name and non-formulary generic drugs

All prescription fills must be through our preferred Aetna Specialty Pharmacy network.

Choose Generics - If the member or the physician requests brand-name when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.



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Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Diabetic Supplies and Insulin - \$0 copay

A limited list of over-the-counter medications are covered when filled with a prescription.

Standard Pre-certification included

Standard Step Therapy included

One transition fill allowed within 90 days of member's effective date

Formulary generic FDA - approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

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.

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 or inadequacies, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.



School Board of Broward County – Basic Kids
Effective Date: 01-01-2023
Aetna Open Access® Aetna SelectSM

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Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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 traducción 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**.

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