School Board of Broward County – Premier Plus
Effective Date: 01-01-2023
Aetna Open Access® Aetna Select℠

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

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year) Pharmacy expenses do not apply towards the Deductible.	$250 Individual $500 Family
Member Coinsurance Applies to all expenses unless otherwise stated.	10% coinsurance
Payment Limit (per calendar year) 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.	$2,000 Individual $4,000 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	Covered 100%
Routine Well Child Exams	Covered 100%
Routine Gynecological Care Exams Recommended: One exam per calendar year. Includes routine tests and related lab fees.	Covered 100%
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%
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.	Covered 100%
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Covered 100%
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%
Routine Hearing Screening	Covered 100%

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PHYSICIAN SERVICES	IN-NETWORK
Primary Care Physician Visits	$25 copay*
Includes services of an internist, general physician, family practitioner or pediatrician. *Dermatology, Podiatry, OB/GYN and Chiropractic services will follow this copay.	
Specialist Office Visits	$45 copay
Audiometric Hearing Exam	Not Covered
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	$25 copay
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	10% coinsurance; 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	Covered 100%
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	$150 copay at Hospital; $45 copay at Freestanding Facility

EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent Care Provider	$40 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$300 copay
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	10% coinsurance; after deductible
Non-Emergency but Medically Necessary Use of Ambulance	10% coinsurance; after deductible
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	$250 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care –no separate office copay for postnatal)	$250 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Hospital	10% coinsurance; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Hospital	$250 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	

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Outpatient Surgery - Freestanding Facility The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	$50 copay
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	$250 copay
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$25 copay
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	$250 copay
Residential Treatment Facility	$250 copay
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$25 copay
OTHER SERVICES	**IN-NETWORK**
Convalescent Facility Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	10% coinsurance; after deductible
Home Health Care 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.	$10 copay
Hospice Care – Inpatient Limited to 210 days lifetime maximum combined for inpatient and outpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	10% coinsurance; after deductible
Hospice Care – Outpatient Limited to 210 days lifetime maximum combined for inpatient and outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	10% coinsurance; after deductible
Private Duty Nursing	Not Covered
Outpatient Short-Term Rehabilitation Includes Physical, Occupational and Speech Therapy	$25 copay
Spinal Manipulation Therapy	$25 copay
Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis	$25 copay
Autism Physical Therapy	$25 copay
Autism Occupational Therapy	$25 copay
Autism Speech Therapy	$25 copay
Durable Medical Equipment	10% coinsurance; after deductible
Hearing Aids	$300 allowance every 12 months

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Prosthetics	10% coinsurance; after deductible
Orthotics	10% coinsurance; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered 100%
Generic FDA-approved Women's Contraceptives	Covered 100%
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Transplants	$250 copay Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	$250 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
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 (Includes Artificial Insemination and Ovulation Induction. Both Comprehensive and ART services are combined to a maximum of 3 cycles per lifetime.)	40% coinsurance
Advanced Reproductive Technology (ART)	40% coinsurance
Both Comprehensive and ART services are combined to a maximum of 3 cycles per lifetime. ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.	
Vasectomy	$200 copay
Tubal Ligation	Covered 100%
PHARMACY	**IN-NETWORK**
Pharmacy Plan Type **Pharmacy Maximum** $4,500 / Individual $9,000 Family	Aetna Standard Formulary
Retail	$6 copay for tier 1A formulary generic drugs, $10 copay for formulary generic drugs; $50 copay for formulary brand-name drugs, and $75 copay for non-formulary brand-name and non-formulary generic drugs up to a 30 day supply at participating pharmacies.
Mail Order	$6 copay for tier 1A formulary generic drugs, $10 copay for formulary generic drugs; $100 copay for formulary brand-name drugs, and $150 copay for non-formulary brand-name and non-formulary generic drugs Up to a 31-90 day supply from Aetna Rx Home Delivery®.

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Aetna Standard Specialty Drugs	$10 copay for formulary generic drugs; $50 copay for formulary brand-name drugs, and $75 copay for non-formulary brand-name and non-formulary generic drugs from Aetna Specialty Pharmacy Network.
CVS Maintenance Choice (90) Day Supply at Retail	$6 copay for tier 1A formulary generic drugs, $10 copay for formulary generic drugs; $100 copay for formulary brand-name drugs, and $150 copay for non-formulary brand-name and non-formulary generic drugs

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

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.

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

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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.

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 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.**

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