SCHOOL DISTRICT OF HENDRY COUNTY

Section VIII

Exposure, Loss Data, And Contract Provisions

SECTION VIII

EXPOSURE, LOSS DATA AND CONTRACT PROVISIONS

SOURCE OF INFORMATION

The School District of Hendry County, and current vendors and carriers supplied all data and statistical information. In some instances, data was retyped for clarity. If there are omissions, additional data is not readily available.

Exhibit 1 –Plan Information and Medical Rates and Monthly Contributions for 2019 - 2022

Exhibit 2 – Medical and Prescription Experience Reports

Exhibit 3 – Benefits Match-Up – a,b,c (In Word format)

Exhibit 4 – Most Utilized Provider Comparison Match-Up (In Excel format)

Exhibit 5 –Wellness Information

Exhibit 6 – Medical Census (In Excel format)

A request for any documents in Word or Excel may be made to:

Theresa Conley
Siver Insurance Consultants
tconley@siver.com

EXHIBIT 1

Plan Information and Medical Rates and Monthly Contributions for 2019 - 2022

School Board of Hendry County
Medical Historical Cost Review

Plan and Tier	2022	2021	2020	2019	2018	2017	2016
	Aetna	Aetna	Aetna	Aetna	Florida Blue	Florida Blue	UHC
	Open Access MC 1	Open Access MC 1	Open Access MC 1	Open Access MC 1	BlueOptions 03564	BlueOptions 03564	AHLV-M
Employee Only	$791.32	$744.92	$702.75	$684.94	$761.04	$601.43	$703.43
Emp + Spouse	$1,740.91	$1,638.83	$1,546.07	$1,506.89	$1,674.32	$1,323.16	$1,547.55
Emp + Child(ren)	$1,582.64	$1,489.84	$1,405.51	$1,369.89	$1,522.10	$1,202.86	$1,406.85
Family	$2,215.69	$2,085.77	$1,967.71	$1,917.85	$2,130.94	$1,684.01	$1,969.60
	Open Access MC 2	Open Access MC 2	Open Access MC 2	Open Access MC 2	BlueOptions 05302	BlueOptions 05302	AHMK
Employee Only	$636.90	$599.57	$565.63	$551.30	$612.55	$484.08	$566.18
Emp + Spouse	$1,401.26	$1,319.10	$1,244.43	$1,212.89	$1,347.65	$1,065.00	$1,245.61
Emp + Child(ren)	$1,273.86	$1,199.17	$1,131.29	$1,102.62	$1,225.13	$968.11	$1,132.38
Family	$1,783.40	$1,678.83	$1,583.80	$1,543.66	$1,715.18	$1,358.45	$1,585.32
	Open Access MC 5000 HSA	Open Access MC 5000 HSA	Open Access MC 5000 HSA	Open Access MC 5000 HSA	BlueOptions 05903/05173 (HSA)	BlueOptions 05903/05173 (HSA)	AHI4 MOD (HSA)
Employee Only	$530.24	$499.16	$470.91	$458.98	$509.98	$403.02	$471.37
Emp + Spouse	$1,166.57	$1,098.17	$1,036.01	$1,009.76	$1,121.95	$886.64	$1,037.01
Emp + Child(ren)	$1,060.51	$998.33	$941.82	$917.95	$1,019.94	$806.03	$942.73
Family	$1,484.72	$1,397.67	$1,318.56	$1,285.15	$1,427.94	$1,128.45	$1,319.83

*all % changes are based on current enrollment for that year

2019 Plan Documents

HENDRY DISTRICT SCHOOL BOARD
Aetna and Other Benefit Rates
Calendar Year 2019 Aetna PREMIUMS
(For Period January 1 through December 31, 2019)

Employees

FAMILY HEALTH INSURANCE COVERAGE	Aenta CY 2019 24 PAY Per Pay	Aetna CY 2019 21 PAY Per Pay	Aetna CY 2019 *Annual* Cost
Open Access MC 1			
Employee	**$0**	**$0**	**$0**
Employee-Spouse	**$404**	**$462**	**$9,695**
Employee-Children	**$335**	**$383**	**$8,051**
Family	**$609**	**$696**	**$14,626**
Both spouses work for District (Family)	**$260**	**$297**	**$6,238**
Open Access MC 2			
Employee	**$0**	**$0**	**$0**
Employee-Spouse	**$257**	**$294**	**$6,167**
Employee-Children	**$202**	**$231**	**$4,843**
Family	**$422**	**$483**	**$10,136**
Both spouses work for District (Family)	**$73**	**$83**	**$1,748**
Open Access MC3 HRA/HSA			
Employee (HRA)	**$0**	**$0**	**$0**
Employee-Spouse (Health Savings Plan)	**$155**	**$178**	**$3,720**
Employee-Children (Health Savings Plan	**$109**	**$125**	**$2,627**
Family (Health Savings Plan)	**$293**	**$335**	**$7,034**
Both spouses work for District (Family) (Health Savings Plan)	**$0**	**$0**	**$0**
DENTAL, LIFE INSURANCE, DISABILITY			
Employee	**$0**	**$0**	**$0**
Employee-Family	**$9**	**$10**	**$216**
EMPLOYEE LIFE INSURANCE	**$0**	**$0**	**$0**

Employees may purchase family dental insurance, spouse or children life insurance, additional life insurance on themselves, or additional disability insurance at their own expense.

$9,000 Board Benefit Contribution Maximum Per Employee
Benefit for dental and life insurance is $612 Per Employee

Aetna Retiree Premium Rates

RATE FOR CALENDAR YEAR 2019

(For Period January 1 through December 31, 2019)

If retiree chooses to remain on one of the District's Aetna Health Care Plans the retiree pays the FULL cost.

A descision to elect retiree benefits must be made within 30 working days prior to retirement. Failure to respond to enrollment indicates a refusal of coverage. Once a benefit is refused or not elected it cannot be reinstated at a later date. Upon retirement you cannot change or switch medical plan coverage. You are given the oportunity to change plan coverage during the District's annual Open Enrollment period

Retirees

FAMILY HEALTH INSURANCE COVERAGE	2019 Per Month	2019 Annual
Open Access Plan 1		
Retiree	$684.94	$8,219.28
Retiree-Spouse	$1,506.89	$18,082.68
Retiree-Children	$1,369.89	$16,438.68
Family	$1,917.85	$23,014.20
Open Access Plan 2		
Retiree	$551.30	$6,615.60
Retiree-Spouse	$1,212.89	$14,554.68
Retiree-Children	$1,102.62	$13,231.44
Family	$1,543.66	$18,523.92
Open Acces Plan 3 HRA/HSA		
Retiree	$458.98	$5,507.76
Retiree-Spouse	$1,009.76	$12,117.12
Retiree-Children	$917.95	$11,015.40
Family	$1,285.15	$15,421.80
DENTAL		
Employee	$7	$84
Employee-Family	$27	$324
RETIREE LIFE INSURANCE		
Can be purchased at the age based negotiated rate for retirees. Retiree pays full cost for life insurance.	Age Based	Age Based

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Plan 1

School District of Hendry County
Effective Date: 01-01-2019
OAMC 2000 Plan mc1

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 Applies to all expenses unless otherwise stated.	Covered 100%	20%
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$9,000 Individual $18,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	Covered 100%; deductible waived	20%; after deductible
Routine Well Child Exams/Immunizations 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 12 months thereafter to age 22.	Covered 100%; deductible waived	20%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per calendar year	Covered 100%; deductible waived	20%; after deductible

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School District of Hendry County
Effective Date: 01-01-2019
OAMC 2000 & Retirees Only – Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	20%; after deductible
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	20%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$25 copay; deductible waived	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$50 copay; deductible waived	20%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	$25 copay; deductible waived	20%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	20%; 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%; deductible waived	20%; 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 Outpatient Complex Imaging	Covered 100%; after deductible	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 copay; deductible waived	$75 copay; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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School District of Hendry County
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OAMC 2000 & Retirees Only – Florida

PLAN DESIGN & BENEFITS
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Emergency Room Copay waived if admitted	$125 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; deductible waived	20%; deductible waived
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; deductible waived
Other Mental Health Services	Covered 100%; deductible waived	20%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; deductible waived	20%; deductible waived
Residential Treatment Facility	Covered 100%; deductible waived	20%; deductible waived
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; deductible waived
Other Substance Abuse Services	Covered 100%; deductible waived	20%; deductible waived
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counseling and services of a medical social worker. 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.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible

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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$25 copay; deductible waived	20%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	$25 copay; deductible waived	20%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$25 copay; deductible waived	20%; after deductible
Autism Occupational Therapy	$25 copay; deductible waived	20%; after deductible
Autism Speech Therapy	$25 copay; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred provider is not available.	benefit level of the plan if in-network
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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School District of Hendry County
Effective Date: 01-01-2019
OAMC 2000 & Retirees Only – Florida

PLAN DESIGN & BENEFITS
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Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	Not Covered
Mail Order	$20 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	Not Covered
Mail Order	$60 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	Not Covered
Mail Order	$100 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

• 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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

- 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.**

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Plan 2

aetna®

School District of Hendry County
Effective Date: 01-01-2019
OAMC 6000

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$6,000 Individual $12,000 Family	$8,000 Individual $16,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 Applies to all expenses unless otherwise stated.	40%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 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 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per calendar year	Covered 100%; deductible waived	50%; after deductible

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School District of Hendry County
Effective Date: 01-01-2019
OAMC 6000 – Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$40 copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$80 copay; deductible waived	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	$40 copay; deductible waived	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	50%; 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%; deductible waived	50%; 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 Outpatient Complex Imaging	$300 copay; deductible waived	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$100 copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room Copay waived if admitted	$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	40%; after $500 copay; after deductible	50%; after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	40%; after $500 copay; after deductible	50%; after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	40%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	50%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; deductible waived	50%; deductible waived
Substance Abuse Office Visits	$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	50%; deductible waived
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	40%; after deductible	50%; after deductible
Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	40%; after deductible	50%; after deductible
Limited to 60 visits per calendar year. Coverage includes nutritional counseling and services of a medical social worker. 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	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$40 copay; deductible waived	50%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	$40 copay; deductible waived	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$40 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	$40 copay; deductible waived	50%; after deductible
Autism Speech Therapy	$40 copay; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after $500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred provider is not available.	benefit level of the plan if in-network
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	20% of submitted cost; after applicable copay
90 Day Retail	$30 copay	Not Covered
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	20% of submitted cost; after applicable copay
90 Day Retail	$120 copay	Not Covered
Mail Order	$80 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$80 copay	20% of submitted cost; after applicable copay
90 Day Retail	$240 copay	Not Covered
Mail Order	$160 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• 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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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- 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.**

PLAN DESIGN & BENEFITS
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Plan 3

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PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES	
HealthFund Amount	$1,500 Employee
Amount contributed to the Fund by the employer Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage. The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.	
Fund Coinsurance	100%
Percentage at which the Fund will reimburse	
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.
Employee Termination from Your HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's HealthFund coverage terminates.
Fund Rollover	Any remaining HealthFund benefit amount at end of the plan year is rolled over into next year's HealthFund benefit amount.
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.
Pro-ration for New Employees	Monthly
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.
Prescription Drug Plan	Prescription Drug expenses are integrated with the medical plan (i.e., subject to medical Deductible and applied towards the medical Out-of-Pocket Limit) and with the Fund (i.e., eligible for reimbursement from the Fund).

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 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	50%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.		

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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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 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 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per calendar year	Covered 100%; deductible waived	50%; after deductible
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
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%; deductible waived	50%; after deductible
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Covered 100%; deductible waived	Covered 100%; deductible waived
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	50%; after deductible
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	50%; after deductible	50%; after deductible

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Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year. Coverage includes nutritional counseling and services of a medical social worker. 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	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term Rehabilitation	50%; after deductible	50%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.		

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Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible

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PLAN DESIGN & BENEFITS
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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	Not Covered
Mail Order	$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	Not Covered
Mail Order	$75 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	Not Covered
Mail Order	$125 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• 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.

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

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.

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

- 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.**

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Plan 3

School District of Hendry County
Effective Date: 01-01-2019
Open Access® Managed Choice® POS - Florida
OAMC HSA Qualified High Deductible Health Plan

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 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 Applies to all expenses unless otherwise stated.	50%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
1 obgyn exam and pap smear per calendar year		

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PLAN DESIGN & BENEFITS
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Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after $500 copy per admission; after deductible	50%; after $500 copy per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after $500 copy per admission; after deductible	50%; after $500 copy per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counseling and services of a medical social worker.		
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 Your cost sharing applies to all covered benefits incurred during your inpatient stay.	50%; after deductible	50%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	50%; after deductible	50%; after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	50%; after deductible	50%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	50%; after deductible	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	Not Covered
Mail Order	$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	Not Covered
Mail Order	$75 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	Not Covered
Mail Order	$125 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
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GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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- 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.

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PLAN DESIGN & BENEFITS
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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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	Covered 100%	20%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$9,000 Individual $18,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	20%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	20%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	20%; after deductible
1 obgyn exam and pap smear per calendar year		

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	20%; after deductible
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	20%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$25 copay; deductible waived	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$50 copay; deductible waived	20%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	$25 copay; deductible waived	20%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	20%; 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%; deductible waived	20%; 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 Outpatient Complex Imaging	Covered 100%; after deductible	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 copay; deductible waived	$75 copay; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
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Emergency Room Copay waived if admitted	$125 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; deductible waived	20%; deductible waived
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; deductible waived
Other Mental Health Services	Covered 100%; deductible waived	20%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; deductible waived	20%; after deductible
Residential Treatment Facility	Covered 100%; deductible waived	20%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; after deductible
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counseling and services of a medical social worker. 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.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible

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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$25 copay; deductible waived	20%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	$25 copay; deductible waived	20%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$25 copay; deductible waived	20%; after deductible
Autism Occupational Therapy	$25 copay; deductible waived	20%; after deductible
Autism Speech Therapy	$25 copay; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$20 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$60 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$100 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

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• 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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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• 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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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aetna®

School District of Hendry County
Effective Date: 01-01-2019
Open Access® Managed Choice® POS – Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$6,000 Individual $12,000 Family	$8,000 Individual $16,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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	40%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
1 obgyn exam and pap smear per calendar year		

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Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$40 copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$80 copay; deductible waived	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	$40 copay; deductible waived	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	50%; 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%; deductible waived	50%; 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 Outpatient Complex Imaging	$300 copay; deductible waived	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$100 copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room Copay waived if admitted	$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	40%; after $500 copay; after deductible	50%; after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	40%; after $500 copay; after deductible	50%; after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	40%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	50%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; deductible waived	50%; deductible waived
Substance Abuse Office Visits	$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	50%; deductible waived
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	40%; after deductible	50%; after deductible
Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	40%; after deductible	50%; after deductible
Limited to 60 visits per calendar year. Coverage includes nutritional counseling and services of a medical social worker. 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	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$40 copay; deductible waived	50%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	$40 copay; deductible waived	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$40 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	$40 copay; deductible waived	50%; after deductible
Autism Speech Therapy	$40 copay; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after $500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred provider is not available.	benefit level of the plan if in-network
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	20% of submitted cost; after applicable copay
90 Day Retail	$30 copay	
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	20% of submitted cost; after applicable copay
90 Day Retail	$120 copay	
Mail Order	$80 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$80 copay	20% of submitted cost; after applicable copay
90 Day Retail	$240 copay	
Mail Order	$160 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
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GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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• 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.

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If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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• 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.**

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

School District of Hendry County
Effective Date: 01-01-2019
Aetna HealthFund™ Open Access® Managed Choice® POS - Florida

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES		
HealthFund Amount	$1,500 Employee	
Amount contributed to the Fund by the employer Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage. The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.		
Fund Coinsurance	100%	
Percentage at which the Fund will reimburse		
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.	
Employee Termination from Your HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's HealthFund coverage terminates.	
Fund Rollover	Any remaining HealthFund benefit amount at end of the plan year is rolled over into next year's HealthFund benefit amount.	
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.	
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.	
Pro-ration for New Employees	Monthly	
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.	
Prescription Drug Plan	Prescription Drug expenses are integrated with the medical plan (i.e., subject to medical Deductible and applied towards the medical Out-of-Pocket Limit) and with the Fund (i.e., eligible for reimbursement from the Fund).	
PLAN FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible (per calendar year)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 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	50%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
1 obgyn exam and pap smear per calendar year		
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counseling and services of a medical social worker.		
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	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term Rehabilitation	50%; after deductible	50%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$75 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• 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.

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

PLAN DESIGN & BENEFITS
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• 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.

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School District of Hendry County
Effective Date: 01-01-2019
Open Access® Managed Choice® POS - Florida
Qualified High Deductible Health Plan

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 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 Applies to all expenses unless otherwise stated.	50%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 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 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per calendar year	Covered 100%; deductible waived	50%; after deductible

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Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counseling and services of a medical social worker.		
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.		

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	50%; after deductible	50%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	50%; after deductible	50%; after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	50%; after deductible	50%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	50%; after deductible	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$75 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• 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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

PLAN DESIGN & BENEFITS
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• 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.**

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

2020 Plan Documents

HENDRY DISTRICT SCHOOL BOARD
Aetna and Other Benefit Rates
Calendar Year 2020 Aetna PREMIUMS
(For Period January 1 through December 31, 2020)

Employees

FAMILY HEALTH INSURANCE COVERAGE	Aenta CY 2020 24 PAY Per Pay	Aetna CY 2020 21 PAY Per Pay	Aetna CY 2020 *Annual* Cost
Open Access MC 1			
Employee	**$0**	**$0**	**$0**
Employee-Spouse	**$422**	**$482**	**$10,120**
Employee-Children	**$351**	**$402**	**$8,433**
Family	**$632**	**$723**	**$15,180**
Both spouses work for District (Family)	**$281**	**$321**	**$6,747**
Open Access MC 2			
Employee	**$0**	**$0**	**$0**
Employee-Spouse	**$271**	**$310**	**$6,500**
Employee-Children	**$214**	**$245**	**$5,142**
Family	**$441**	**$503**	**$10,573**
Both spouses work for District (Family)	**$89**	**$102**	**$2,140**
Open Access MC3 HRA/HSA			
Employee (HRA)	**$0**	**$0**	**$0**
Employee-Spouse (Health Savings Plan)	**$167**	**$190**	**$3,999**
Employee-Children (Health Savings Plan	**$120**	**$137**	**$2,869**
Family (Health Savings Plan)	**$308**	**$352**	**$7,390**
Both spouses work for District (Family) (Health Savings Plan)	**$0**	**$0**	**$0**
DENTAL, LIFE INSURANCE, DISABILITY			
Employee	**$0**	**$0**	**$0**
Employee-Family	**$9**	**$10**	**$216**
EMPLOYEE LIFE INSURANCE	**$0**	**$0**	**$0**

Employees may purchase family dental insurance, spouse or children life insurance, additional life insurance on themselves, or additional disability insurance at their own expense.

$9,0000 Board Benefit Contribution Maximum Per Employee
Benefit for dental and life insurance is $612 Per Employee

Aetna Retiree Premium Rates

RATE FOR CALENDAR YEAR 2020

(For Period January 1 through December 31, 2020)

If retiree chooses to remain on one of the District's Aetna Health Care Plans the retiree pays the FULL cost.

A descision to elect retiree benefits must be made within 30 working days prior to retirement. Failure to respond to enrollment indicates a refusal of coverage. Once a benefit is refused or not elected it cannot be reinstated at a later date. Upon retirement you cannot change or switch medical plan coverage. You are given the oportunity to change plan coverage during the District's annual Open Enrollment period

Retirees

FAMILY HEALTH INSURANCE COVERAGE	2020 Per Month	2020 Annual
Open Access Plan 1		
Retiree	**$702.75**	**$8,433.00**
Retiree-Spouse	**$1,546.07**	**$18,552.84**
Retiree-Children	**$1,405.51**	**$16,866.12**
Family	**$1,967.71**	**$23,612.52**
Open Access Plan 2		
Retiree	**$565.63**	**$6,787.56**
Retiree-Spouse	**$1,244.43**	**$14,933.16**
Retiree-Children	**$1,131.29**	**$13,575.48**
Family	**$1,583.80**	**$19,005.60**
Open Acces Plan 3 HRA/HSA		
Retiree	**$470.91**	**$5,650.92**
Retiree-Spouse	**$1,036.01**	**$12,432.12**
Retiree-Children	**$941.82**	**$11,301.84**
Family	**$1,318.56**	**$15,822.72**
DENTAL		
Employee	**$7**	**$84**
Employee-Family	**$27**	**$324**
RETIREE LIFE INSURANCE		
Can be purchased at the age based negotiated rate for retirees. Retiree pays full cost for life insurance.	**Age Based**	**Age Based**

aetna®

School District of Hendry County
Effective Date: 01-01-2020
Open Access® Managed Choice® POS – Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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	Covered 100%	20%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$9,000 Individual $18,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	20%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	20%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	20%; after deductible
1 obgyn exam and pap smear per calendar year		

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	20%; after deductible
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	20%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$25 copay; deductible waived	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$50 copay; deductible waived	20%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	$25 copay; deductible waived	20%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	20%; 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%; deductible waived	20%; 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 Outpatient Complex Imaging	Covered 100%; after deductible	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 copay; deductible waived	$75 copay; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
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Emergency Room Copay waived if admitted	$125 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; deductible waived	20%; deductible waived
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; deductible waived
Other Mental Health Services	Covered 100%; deductible waived	20%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; deductible waived	20%; after deductible
Residential Treatment Facility	Covered 100%; deductible waived	20%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; after deductible
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counseling and services of a medical social worker. 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.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible

PLAN DESIGN & BENEFITS
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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$25 copay; deductible waived	20%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	$25 copay; deductible waived	20%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$25 copay; deductible waived	20%; after deductible
Autism Occupational Therapy	$25 copay; deductible waived	20%; after deductible
Autism Speech Therapy	$25 copay; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$20 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$60 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$100 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

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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.

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

PLAN DESIGN & BENEFITS
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• 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.**

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

aetna®

School District of Hendry County
Effective Date: 01-01-2020
Open Access® Managed Choice® POS – Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$6,000 Individual $12,000 Family	$8,000 Individual $16,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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	40%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
1 obgyn exam and pap smear per calendar year		

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$40 copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$80 copay; deductible waived	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	$40 copay; deductible waived	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	50%; 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%; deductible waived	50%; 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 Outpatient Complex Imaging	$300 copay; deductible waived	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$100 copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
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Emergency Room Copay waived if admitted	$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	40%; after $500 copay; after deductible	50%; after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	40%; after $500 copay; after deductible	50%; after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	40%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	50%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; deductible waived	50%; deductible waived
Substance Abuse Office Visits	$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	50%; deductible waived
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	40%; after deductible	50%; after deductible
Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	40%; after deductible	50%; after deductible
Limited to 60 visits per calendar year. Coverage includes nutritional counseling and services of a medical social worker. 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	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

PLAN DESIGN & BENEFITS
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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$40 copay; deductible waived	50%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	$40 copay; deductible waived	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$40 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	$40 copay; deductible waived	50%; after deductible
Autism Speech Therapy	$40 copay; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after $500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred provider is not available.	benefit level of the plan if in-network
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

PLAN DESIGN & BENEFITS
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Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	20% of submitted cost; after applicable copay
90 Day Retail	$30 copay	
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	20% of submitted cost; after applicable copay
90 Day Retail	$120 copay	
Mail Order	$80 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$80 copay	20% of submitted cost; after applicable copay
90 Day Retail	$240 copay	
Mail Order	$160 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• 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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
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• 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.

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PROVIDED BY AETNA LIFE INSURANCE COMPANY

School District of Hendry County
Effective Date: 01-01-2020
Aetna HealthFund™ Open Access® Managed Choice® POS - Florida

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES		
HealthFund Amount Amount contributed to the Fund by the employer Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage. The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.	$1,500 Employee	
Fund Coinsurance Percentage at which the Fund will reimburse	100%	
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.	
Employee Termination from Your HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's HealthFund coverage terminates.	
Fund Rollover	Any remaining HealthFund benefit amount at end of the plan year is rolled over into next year's HealthFund benefit amount.	
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.	
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.	
Pro-ration for New Employees	Monthly	
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.	
Prescription Drug Plan	Prescription Drug expenses are integrated with the medical plan (i.e., subject to medical Deductible and applied towards the medical Out-of-Pocket Limit) and with the Fund (i.e., eligible for reimbursement from the Fund).	
PLAN FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible (per calendar year) All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 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.	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
Member Coinsurance Applies to all expenses unless otherwise stated.	50%	50%
Payment Limit (per calendar year) All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
1 obgyn exam and pap smear per calendar year		
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counseling and services of a medical social worker.		
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	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term Rehabilitation	50%; after deductible	50%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.		

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MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$75 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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• 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.

PLAN DESIGN & BENEFITS
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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.

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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• 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.

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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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School District of Hendry County
Effective Date: 01-01-2020
Open Access® Managed Choice® POS - Florida
Qualified High Deductible Health Plan

PLAN DESIGN & BENEFITS
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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 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	50%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
1 obgyn exam and pap smear per calendar year		

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Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counseling and services of a medical social worker.		
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 Your cost sharing applies to all covered benefits incurred during your inpatient stay.	50%; after deductible	50%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	50%; after deductible	50%; after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	50%; after deductible	50%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	50%; after deductible	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$75 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
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GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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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.

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• 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.

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In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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Plan features and availability may vary by location and group size.
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PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

2021 Plan Documents

HENDRY DISTRICT SCHOOL BOARD
Aetna and Other Benefit Rates
Calendar Year 2021 Aetna PREMIUMS
(For Period January 1 through December 31, 2021)

Employees

FAMILY HEALTH INSURANCE COVERAGE	Aenta CY 2021 24 PAY Per Pay	Aetna CY 2021 21 PAY Per Pay	Aetna CY 2021 *Annual* Cost
Open Access MC 1			
Employee	**$0**	**$0**	**$0**
Employee-Spouse	**$431**	**$493**	**$10,350**
Employee-Children	**$359**	**$411**	**$8,625**
Family	**$647**	**$739**	**$15,524**
Both spouses work for District (Family)	**$288**	**$329**	**$6,900**
Open Access MC 2			
Employee	**$0**	**$0**	**$0**
Employee-Spouse	**$277**	**$317**	**$6,648**
Employee-Children	**$219**	**$250**	**$5,259**
Family	**$451**	**$515**	**$10,813**
Both spouses work for District (Family)	**$91**	**$104**	**$2,188**
Open Access MC3 HRA/HSA			
Employee (HRA)	**$0**	**$0**	**$0**
Employee-Spouse (Health Savings Plan)	**$170**	**$195**	**$4,090**
Employee-Children (Health Savings Plan	**$122**	**$140**	**$2,934**
Family (Health Savings Plan)	**$315**	**$360**	**$7,557**
Both spouses work for District (Family) (Health Savings Plan)	**$0**	**$0**	**$0**
DENTAL, LIFE INSURANCE, DISABILITY			
Employee	**$0**	**$0**	**$0**
Employee-Family	**$9**	**$10**	**$216**
EMPLOYEE LIFE INSURANCE	**$0**	**$0**	**$0**

Employees may purchase family dental insurance, spouse or children life insurance, additional life insurance on themselves, or additional disability insurance at their own expense.

$9,0000 Board Benefit Contribution Maximum Per Employee
Benefit for dental and life insurance is $612 Per Employee

Aetna Retiree Premium Rates

RATE FOR CALENDAR YEAR 2021

(For Period January 1 through December 31, 2021)

If retiree chooses to remain on one of the District's Aetna Health Care Plans the retiree pays the FULL cost.

A descision to elect retiree benefits must be made within 30 working days prior to retirement. Failure to respond to enrollment indicates a refusal of coverage. Once a benefit is refused or not elected it cannot be reinstated at a later date. Upon retirement you cannot change or switch medical plan coverage. You are given the oportunity to change plan coverage during the District's annual Open Enrollment period

Retirees

FAMILY HEALTH INSURANCE COVERAGE	2021 Per Month	2021 Annual
Open Access Plan 1		
Retiree	**$718.70**	**$8,624.40**
Retiree-Spouse	**$1,581.17**	**$18,974.04**
Retiree-Children	**$1,437.42**	**$17,249.04**
Family	**$2,012.38**	**$24,148.56**
Open Access Plan 2		
Retiree	**$578.47**	**$6,941.64**
Retiree-Spouse	**$1,272.68**	**$15,272.16**
Retiree-Children	**$1,156.97**	**$13,883.64**
Family	**$1,619.75**	**$19,437.00**
Open Acces Plan 3 HRA Only - No Card Issued		
Retiree	**$481.60**	**$5,779.20**
Retiree-Spouse	**$1,059.53**	**$12,714.36**
Retiree-Children	**$963.20**	**$11,558.40**
Family	**$1,348.49**	**$16,181.88**
DENTAL		
Employee	**$7**	**$84**
Employee-Family	**$27**	**$324**
RETIREE LIFE INSURANCE		
Can be purchased at the age based negotiated rate for retirees. Retiree pays full cost for life insurance.	**Age Based**	**Age Based**

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Plan Open Access MC1

School District of Hendry County
Effective Date: 01-01-2021
Open Access® Managed Choice® POS – Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 Applies to all expenses unless otherwise stated.	Covered 100%	20%
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$9,000 Individual $18,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	Covered 100%; deductible waived	20%; after deductible
Routine Well Child Exams/Immunizations 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 12 months thereafter to age 22.	Covered 100%; deductible waived	20%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per calendar year	Covered 100%; deductible waived	20%; after deductible

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PLAN DESIGN & BENEFITS
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Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	20%; after deductible
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	20%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$25 copay; deductible waived	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$50 copay; deductible waived	20%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	$25 copay; deductible waived	20%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	20%; 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%; deductible waived	20%; 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 Outpatient Complex Imaging	Covered 100%; after deductible	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 copay; deductible waived	$75 copay; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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School District of Hendry County
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Open Access® Managed Choice® POS – Florida

PLAN DESIGN & BENEFITS
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Emergency Room Copay waived if admitted	$125 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; deductible waived	20%; deductible waived
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; deductible waived
Other Mental Health Services	Covered 100%; deductible waived	20%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; deductible waived	20%; after deductible
Residential Treatment Facility	Covered 100%; deductible waived	20%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; after deductible
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counseling and services of a medical social worker. 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.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible

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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$25 copay; deductible waived	20%; after deductible
Outpatient Short-Term Rehabilitation	$25 copay; deductible waived	20%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.		
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	$25 copay; deductible waived	20%; after deductible
Autism Occupational Therapy	$25 copay; deductible waived	20%; after deductible
Autism Speech Therapy	$25 copay; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred provider is not available.	benefit level of the plan if in-network
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		

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Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$20 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$60 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$100 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

PLAN DESIGN & BENEFITS
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• 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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

PLAN DESIGN & BENEFITS
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- 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.**

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PLAN DESIGN & BENEFITS
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Plan Open Access MC2

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School District of Hendry County
Effective Date: 01-01-2021
Open Access® Managed Choice® POS – Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$6,000 Individual $12,000 Family	$8,000 Individual $16,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 Applies to all expenses unless otherwise stated.	40%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 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 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per calendar year	Covered 100%; deductible waived	50%; after deductible

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School District of Hendry County
Effective Date: 01-01-2021
Open Access® Managed Choice® POS – Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$40 copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$80 copay; deductible waived	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	$40 copay; deductible waived	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	50%; 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%; deductible waived	50%; 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 Outpatient Complex Imaging	$300 copay; deductible waived	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$100 copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room Copay waived if admitted	$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	40%; after $500 copay; after deductible	50%; after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	40%; after $500 copay; after deductible	50%; after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	40%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	50%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; deductible waived	50%; deductible waived
Substance Abuse Office Visits	$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	50%; deductible waived
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	40%; after deductible	50%; after deductible
Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	40%; after deductible	50%; after deductible
Limited to 60 visits per calendar year. Coverage includes nutritional counseling and services of a medical social worker. 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	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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School District of Hendry County
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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$40 copay; deductible waived	50%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	$40 copay; deductible waived	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$40 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	$40 copay; deductible waived	50%; after deductible
Autism Speech Therapy	$40 copay; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after $500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	20% of submitted cost; after applicable copay
90 Day Retail	$30 copay	
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	20% of submitted cost; after applicable copay
90 Day Retail	$120 copay	
Mail Order	$80 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$80 copay	20% of submitted cost; after applicable copay
90 Day Retail	$240 copay	
Mail Order	$160 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

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• 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.

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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PLAN DESIGN & BENEFITS
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- 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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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Plan Open Access MC 3 HRA

School District of Hendry County
Effective Date: 01-01-2021
Aetna HealthFund™ Open Access® Managed Choice® POS - Florida

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES		
HealthFund Amount	$1,500 Employee	
Amount contributed to the Fund by the employer Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage. The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.		
Fund Coinsurance	100%	
Percentage at which the Fund will reimburse		
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.	
Employee Termination from Your HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's HealthFund coverage terminates.	
Fund Rollover	Any remaining HealthFund benefit amount at end of the plan year is rolled over into next year's HealthFund benefit amount.	
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.	
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.	
Pro-ration for New Employees	Monthly	
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.	
Prescription Drug Plan	Prescription Drug expenses are integrated with the medical plan (i.e., subject to medical Deductible and applied towards the medical Out-of-Pocket Limit) and with the Fund (i.e., eligible for reimbursement from the Fund).	
PLAN FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible (per calendar year)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 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	50%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.		

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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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
1 obgyn exam and pap smear per calendar year		
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counseling and services of a medical social worker.		
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	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term Rehabilitation	50%; after deductible	50%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred provider is not available.	benefit level of the plan if in-network
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible

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School District of Hendry County
Effective Date: 01-01-2021
Aetna HealthFund™ Open Access® Managed Choice® POS - Florida

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$75 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
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Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

- 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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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Plan Open Access MC 3 HSA

School District of Hendry County
Effective Date: 01-01-2021
Open Access® Managed Choice® POS - Florida
Qualified High Deductible Health Plan

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. 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 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 Applies to all expenses unless otherwise stated.	50%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. 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.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; deductible waived
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 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
1 obgyn exam and pap smear per calendar year		

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Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (Includes delivery and postpartum care)	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after $250 copay; after deductible	50%; after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after $500 copay per admission; after deductible	50%; after $500 copay per admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counseling and services of a medical social worker.		
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 Your cost sharing applies to all covered benefits incurred during your inpatient stay.	50%; after deductible	50%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	50%; after deductible	50%; after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	50%; after deductible	50%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.	50%; after deductible	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$75 copay	Not Covered
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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PLAN DESIGN & BENEFITS
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**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• 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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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PLAN DESIGN & BENEFITS
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- 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.

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 refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.**

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Plan features and availability may vary by location and group size.
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PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

your Hendry County Pocketpal to find answers to all of your benefit questions.

The information included in this portal is a high-level summary of common benefits. For more details about your plans, please refer to your Plan Document, Summary Plan Description or Certificate of Insurance Coverage. The information in those formal plan documents governs.

2022 Plan Documents

HENDRY DISTRICT SCHOOL BOARD
Aetna and Other Benefit Rates
Calendar Year 2022 Aetna PREMIUMS
(For Period January 1 through December 31, 2022)

Employees

FAMILY HEALTH INSURANCE COVERAGE	Aenta CY 2022 24 PAY Per Pay	Aetna CY 2022 21 PAY Per Pay	Aetna CY 2022 *Annual* Cost
Open Access MC 1			
Employee	**$0**	**$0**	**$0**
Employee-Spouse	**$475**	**$543**	**$11,395**
Employee-Children	**$396**	**$452**	**$9,496**
Family	**$712**	**$814**	**$17,092**
Both spouses work for District (Family)	**$317**	**$362**	**$7,597**
Open Access MC 2			
Employee	**$0**	**$0**	**$0**
Employee-Spouse	**$305**	**$349**	**$7,319**
Employee-Children	**$241**	**$276**	**$5,790**
Family	**$496**	**$567**	**$11,905**
Both spouses work for District (Family)	**$100**	**$115**	**$2,409**
Open Access MC3 HRA/HSA			
Employee (HRA)	**$0**	**$0**	**$0**
Employee-Spouse (Health Savings Plan)	**$188**	**$214**	**$4,503**
Employee-Children (Health Savings Plan	**$135**	**$154**	**$3,230**
Family (Health Savings Plan)	**$347**	**$396**	**$8,321**
Both spouses work for District (Family) (Health Savings Plan)	**$0**	**$0**	**$0**
DENTAL, LIFE INSURANCE, DISABILITY			
Employee	**$0**	**$0**	**$0**
Employee-Family	**$9**	**$10**	**$216**
EMPLOYEE LIFE INSURANCE	**$0**	**$0**	**$0**

Employees may purchase family dental insurance, spouse or children life insurance, additional life insurance on themselves, or additional disability insurance at their own expense.

$9,0000 Board Benefit Contribution Maximum Per Employee
Benefit for dental and life insurance is $612 Per Employee

Aetna Retiree Premium Rates
RATE FOR CALENDAR YEAR 2022
(For Period January 1 through December 31, 2022)

If retiree chooses to remain on one of the District's Aetna Health Care Plans the retiree pays the FULL cost.

A descision to elect retiree benefits must be made within 30 working days prior to retirement. Failure to respond to enrollment indicates a refusal of coverage. Once a benefit is refused or not elected it cannot be reinstated at a later date. Upon retirement you cannot change or switch medical plan coverage. You are given the oportunity to change plan coverage during the District's annual Open Enrollment period

Retirees

FAMILY HEALTH INSURANCE COVERAGE	2022 Per Month	2022 Annual
Open Access Plan 1		
Retiree	$791.32	$9,495.84
Retiree-Spouse	$1,740.91	$20,890.92
Retiree-Children	$1,582.64	$18,991.68
Family	$2,215.69	$26,588.28
Open Access Plan 2		
Retiree	$636.90	$7,642.80
Retiree-Spouse	$1,401.26	$16,815.12
Retiree-Children	$1,273.86	$15,286.32
Family	$1,783.40	$21,400.80
Open Acces Plan 3 HRA Only - No Card Issued		
Retiree	$530.24	$6,362.88
Retiree-Spouse	$1,166.57	$13,998.84
Retiree-Children	$1,060.51	$12,726.12
Family	$1,484.72	$17,816.64
DENTAL		
Employee	$7	$84
Employee-Family	$27	$324
RETIREE LIFE INSURANCE		
Can be purchased at the age based negotiated rate for retirees. Retiree pays full cost for life insurance.	Age Based	Age Based

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School Board of Hendry County Florida
Effective Date: 01-01-2022
Open Access® Managed Choice® POS - Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-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	$4,000 Individual $8,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. 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 Applies to all expenses unless otherwise stated.	Covered 100%	20%
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$9,000 Individual $18,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. 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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	20%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	20%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year Includes routine tests and related lab fees.	Covered 100%; deductible waived	20%; after deductible

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms	Covered 100%; deductible waived	20%; after deductible
Women's Health	Covered 100%; deductible waived	20%; after deductible
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	20%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	20%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP)	$25 office visit copay; deductible waived	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$50 office visit copay; deductible waived	20%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	$25 copay; deductible waived **Designated Walk-in Clinics** Covered 100%; deductible waived	20%; after deductible
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.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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; Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; after deductible	20%; 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%; after deductible	20%; 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 Outpatient Complex Imaging	Covered 100%; after deductible	20%; 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.		

PLAN DESIGN & BENEFITS
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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	$75 office visit copay; deductible waived	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	Covered 100%; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	20%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	20%; after deductible
Substance Abuse Office Visits	Covered 100%; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care Limited to 60 visits per year Private Duty Nursing not covered Coverage includes nutritional counseling and services of a medical social worker. Reimbursement may not be limited to less than $1,000 per year even if the maximum number of visits has been reached. 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	20%; after deductible
Hospice Care - Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		

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Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per year	$25 copay; deductible waived	20%; after deductible
Outpatient Short-Term Rehabilitation Limited to 20 visits per year. Includes speech, physical, occupational therapy	$25 copay; deductible waived	20%; after deductible
Habilitative Physical Therapy	Covered 100%; deductible waived	20%; after deductible
Habilitative Occupational Therapy	Covered 100%; deductible waived	20%; after deductible
Habilitative Speech Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Covered 100%; deductible waived	20%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Covered 100%; deductible waived	20%; after deductible
Autism Physical Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Occupational Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Speech Therapy	Covered 100%; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	$50 copay; deductible waived	20%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	$25 copay; deductible waived	20%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

PLAN DESIGN & BENEFITS
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Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$60 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$100 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	

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

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Precertification and quantity limits included
Step Therapy included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

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

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• 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.

PLAN DESIGN & BENEFITS
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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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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- 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 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.**
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.

aetna

School Board of Hendry County Florida
Effective Date: 01-01-2022
Open Access® Managed Choice® POS - Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	$6,000 Individual $12,000 Family	$8,000 Individual $16,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. 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 Applies to all expenses unless otherwise stated.	40%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. 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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year Includes routine tests and related lab fees.	Covered 100%; deductible waived	50%; after deductible

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Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	50%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP)	$40 office visit copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$80 office visit copay; deductible waived	50%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	$40 copay; deductible waived **Designated Walk-in Clinics** Covered 100%; deductible waived	50%; after deductible
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.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	50%; 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%; deductible waived	50%; 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 Outpatient Complex Imaging	$300 copay; deductible waived	50%; 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.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$100 office visit copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room Copay waived if admitted	$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	40%; after deductible	50%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	40%; after deductible	50%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	40%; after deductible	50%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	40%; after deductible; after $250 copay	50%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	40%; after deductible; after $250 copay	50%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	50%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$80 copay; deductible waived	50%; after deductible
Other Mental Health Services	Covered 100%; deductible waived	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	50%; after deductible
Residential Treatment Facility	Covered 100%; after deductible	50%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$80 copay; deductible waived	50%; after deductible
Other Substance Abuse Services	Covered 100%; deductible waived	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	40%; after deductible	50%; after deductible
Home Health Care Limited to 60 visits per year Private Duty Nursing not covered Coverage includes nutritional counseling and services of a medical social worker. Reimbursement may not be limited to less than $1,000 per year even if the maximum number of visits has been reached. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	40%; after deductible	50%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	40%; after deductible	50%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	40%; after deductible	50%; after deductible

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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per year	$40 copay; deductible waived	50%; after deductible
Outpatient Short-Term Rehabilitation Limited to 20 visits per year. Includes speech, physical, occupational therapy	$40 copay; deductible waived	50%; after deductible
Habilitative Physical Therapy	Covered 100%; deductible waived	50%; after deductible
Habilitative Occupational Therapy	Covered 100%; deductible waived	50%; after deductible
Habilitative Speech Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	$80 copay; deductible waived	50%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Covered 100%; deductible waived	50%; after deductible
Autism Physical Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Occupational Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Speech Therapy	Covered 100%; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	$80 copay; deductible waived	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	$40 copay; deductible waived	50%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

PLAN DESIGN & BENEFITS
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Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$10 copay	20% of submitted cost; after applicable in-network cost share
90 Day Retail	$30 copay	
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	20% of submitted cost; after applicable in-network cost share
90 Day Retail	$120 copay	
Mail Order	$80 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$80 copay	20% of submitted cost; after applicable in-network cost share
90 Day Retail	$240 copay	
Mail Order	$160 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Precertification and quantity limits included Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• 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.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

• 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.

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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- 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 the material into another language may be available. Please call Member Services at **1-888-982-3862.**

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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.

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School Board of Hendry County Florida
Effective Date: 01-01-2022
Aetna HealthFund™ Open Access® Managed Choice® POS - Florida

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY HSA

FUND FEATURES	
HealthFund Amount	$1,500 Employee
Amount contributed to the Fund by the employer Fund amount reflected is on a per year basis. The fund received may be prorated based on your effective date of coverage. The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.	
Fund Coinsurance Percentage at which the Fund will reimburse	100%
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.
Employee Termination from Your HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's HealthFund coverage terminates.
Fund Rollover	Any remaining HealthFund benefit amount at end of the year is rolled over into next year's HealthFund benefit amount.
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.
Pro-ration for New Employees	Monthly
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.
Prescription Drug Plan	Prescription Drug expenses are integrated with the medical plan (i.e., subject to medical Deductible and applied towards the medical Out-of-Pocket Limit) and with the Fund (i.e., eligible for reimbursement from the Fund).

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. 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 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 Applies to all expenses unless otherwise stated.	50%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit.		

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MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year Includes routine tests and related lab fees.	Covered 100%; deductible waived	50%; after deductible
Routine Mammograms	Covered 100%; deductible waived	50%; after 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.	Covered 100%; deductible waived	50%; after deductible
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived	50%; after deductible
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	50%; after deductible
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician.	50%; after deductible	50%; after deductible
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible **Designated Walk-in Clinics** Covered 100%; deductible waived	50%; after deductible
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.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; 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.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		

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Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after deductible	50%; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per year		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per year		
Private Duty Nursing not covered		
Coverage includes nutritional counseling and services of a medical social worker. Reimbursement may not be limited to less than $1,000 per year even if the maximum number of visits has been reached.		
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per year		
Outpatient Short-Term Rehabilitation	50%; after deductible	50%; after deductible
Limited to 20 visits per therapy, per year.		
Includes speech, physical, occupational therapy		
Habilitative Physical Therapy	50%; after deductible	50%; after deductible
Habilitative Occupational Therapy	50%; after deductible	50%; after deductible
Habilitative Speech Therapy	50%; after deductible	50%; after deductible
Autism Behavioral Therapy	50%; after deductible	50%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	50%; after deductible	50%; after deductible
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.

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Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	50%; after deductible	50%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Advanced Reproductive Technology (ART) 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.	Not Covered	Not Covered
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$75 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Precertification and quantity limits included Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

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- Hearing aids
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- 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.

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School Board of Hendry County Florida
Effective Date: 01-01-2022
Open Access® Managed Choice® POS - Florida
Qualified High Deductible Health Plan

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

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PLAN FEATURES	IN-NETWORK	OUT-OF-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)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. 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 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 Applies to all expenses unless otherwise stated.	50%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. 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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year Includes routine tests and related lab fees.	Covered 100%; deductible waived	50%; after deductible

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Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	50%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP)	50%; after deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible **Designated Walk-in Clinics** Covered 100%; after deductible	50%; after deductible
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.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; 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.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after deductible	50%; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per year Private Duty Nursing not covered Coverage includes nutritional counseling and services of a medical social worker. Reimbursement may not be limited to less than $1,000 per year even if the maximum number of visits has been reached. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per year		

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Outpatient Short-Term Rehabilitation Limited to 30 visits per year. Includes speech, physical, occupational therapy	50%; after deductible	50%; after deductible
Habilitative Physical Therapy	50%; after deductible	50%; after deductible
Habilitative Occupational Therapy	50%; after deductible	50%; after deductible
Habilitative Speech Therapy	50%; after deductible	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	50%; after deductible	50%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	50%; after deductible	50%; after deductible
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	50%; after deductible	50%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$75 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Precertification and quantity limits included Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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• 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.

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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- 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.

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Plan features and availability may vary by location and group size.
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PLAN FEATURES	IN-NETWORK	OUT-OF-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	$4,000 Individual $8,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. 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 Applies to all expenses unless otherwise stated.	Covered 100%	20%
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$9,000 Individual $18,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. 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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	20%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	20%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year Includes routine tests and related lab fees.	Covered 100%; deductible waived	20%; after deductible

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Routine Mammograms	Covered 100%; deductible waived	20%; after deductible
Women's Health	Covered 100%; deductible waived	20%; after deductible
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	20%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	20%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP)	$25 office visit copay; deductible waived	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$50 office visit copay; deductible waived	20%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	$25 copay; deductible waived **Designated Walk-in Clinics** Covered 100%; deductible waived	20%; after deductible
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.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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; Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; after deductible	20%; 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%; after deductible	20%; 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 Outpatient Complex Imaging	Covered 100%; after deductible	20%; 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.		

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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	$75 office visit copay; deductible waived	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; after deductible
Other Mental Health Services	Covered 100%; deductible waived	20%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Residential Treatment Facility	Covered 100%; after deductible	20%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; deductible waived	20%; after deductible
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Home Health Care Limited to 60 visits per year Private Duty Nursing not covered Coverage includes nutritional counseling and services of a medical social worker. Reimbursement may not be limited to less than $1,000 per year even if the maximum number of visits has been reached. 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	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible

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Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per year	$25 copay; deductible waived	20%; after deductible
Outpatient Short-Term Rehabilitation Limited to 20 visits per year. Includes speech, physical, occupational therapy	$25 copay; deductible waived	20%; after deductible
Habilitative Physical Therapy	Covered 100%; deductible waived	20%; after deductible
Habilitative Occupational Therapy	Covered 100%; deductible waived	20%; after deductible
Habilitative Speech Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Covered 100%; deductible waived	20%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Covered 100%; deductible waived	20%; after deductible
Autism Physical Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Occupational Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Speech Therapy	Covered 100%; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	$50 copay; deductible waived	20%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	$25 copay; deductible waived	20%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$15 copay	$15 copay
90 Day Retail	$45 copay	
Mail Order	$30 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$100 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$85 copay	$85 copay
90 Day Retail	$255 copay	
Mail Order	$170 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
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GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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• 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.
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• Home births
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• 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.

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PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	$6,000 Individual $12,000 Family	$8,000 Individual $16,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. 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 Applies to all expenses unless otherwise stated.	40%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. 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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year Includes routine tests and related lab fees.	Covered 100%; deductible waived	50%; after deductible

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	50%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP)	$40 office visit copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$80 office visit copay; deductible waived	50%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	$40 copay; deductible waived **Designated Walk-in Clinics** Covered 100%; deductible waived	50%; after deductible
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.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived	50%; 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%; deductible waived	50%; 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 Outpatient Complex Imaging	$300 copay; deductible waived	50%; 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.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$100 office visit copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
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Emergency Room Copay waived if admitted	$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	40%; after deductible; after $250 copay	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	40%; after deductible; after $250 copay	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$80 copay; deductible waived	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	50%; after deductible
Substance Abuse Office Visits	$80 copay; deductible waived	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care Limited to 60 visits per year Private Duty Nursing not covered	40%; after deductible	50%; after deductible
Coverage includes nutritional counseling and services of a medical social worker. Reimbursement may not be limited to less than $1,000 per year even if the maximum number of visits has been reached. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	40%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per year	$40 copay; deductible waived	50%; after deductible
Outpatient Short-Term Rehabilitation Limited to 20 visits per year. Includes speech, physical, occupational therapy	$40 copay; deductible waived	50%; after deductible
Habilitative Physical Therapy	Covered 100%; deductible waived	50%; after deductible
Habilitative Occupational Therapy	Covered 100%; deductible waived	50%; after deductible
Habilitative Speech Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	$80 copay; deductible waived	50%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Covered 100%; deductible waived	50%; after deductible
Autism Physical Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Occupational Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Speech Therapy	Covered 100%; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	$80 copay; deductible waived	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	$40 copay; deductible waived	50%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred provider is not available.	benefit level of the plan if in-network
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

PLAN DESIGN & BENEFITS
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Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$15 copay	20% of submitted cost; after applicable in-network cost share
90 Day Retail	$30 copay	
Mail Order	$30 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$50 copay	20% of submitted cost; after applicable in-network cost share
90 Day Retail	$150 copay	
Mail Order	$100 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$85 copay	20% of submitted cost; after applicable in-network cost share
90 Day Retail	$255 copay	
Mail Order	$170 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Precertification and quantity limits included Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• 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 Life Insurance Company. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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• 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 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.**
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.

aetna

School Board of Hendry County Florida
Effective Date: 01-01-2022
Open Access® Managed Choice® POS - Florida
Qualified High Deductible Health Plan

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. 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 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 Applies to all expenses unless otherwise stated.	50%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. 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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
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	50%; 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 1 obgyn exam and pap smear per year Includes routine tests and related lab fees.	Covered 100%; deductible waived	50%; after deductible

PLAN DESIGN & BENEFITS
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Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Women's Health	Covered 100%; deductible waived	50%; after deductible
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	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	50%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP)	50%; after deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible **Designated Walk-in Clinics** Covered 100%; after deductible	50%; after deductible
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.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; 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.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after deductible	50%; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per year Private Duty Nursing not covered Coverage includes nutritional counseling and services of a medical social worker. Reimbursement may not be limited to less than $1,000 per year even if the maximum number of visits has been reached. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per year		

PLAN DESIGN & BENEFITS
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Outpatient Short-Term Rehabilitation Limited to 30 visits per year. Includes speech, physical, occupational therapy	50%; after deductible	50%; after deductible
Habilitative Physical Therapy	50%; after deductible	50%; after deductible
Habilitative Occupational Therapy	50%; after deductible	50%; after deductible
Habilitative Speech Therapy	50%; after deductible	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	50%; after deductible	50%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	50%; after deductible	50%; after deductible
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	50%; after deductible	50%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred provider is not available.	benefit level of the plan if in-network
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
Mail Order	$75 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Precertification and quantity limits included Step Therapy included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

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• 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.

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

PLAN DESIGN & BENEFITS
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• 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 the material into another language may be available. Please call Member Services at **1-888-982-3862.**

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aetna™

School Board of Hendry County Florida
Effective Date: 01-01-2022
Aetna HealthFund™ Open Access® Managed Choice® POS - Florida

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES	
HealthFund Amount	$1,500 Employee Amount contributed to the Fund by the employer Fund amount reflected is on a per year basis. The fund received may be prorated based on your effective date of coverage. The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.
Fund Coinsurance Percentage at which the Fund will reimburse	100%
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.
Employee Termination from Your HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's HealthFund coverage terminates.
Fund Rollover	Any remaining HealthFund benefit amount at end of the year is rolled over into next year's HealthFund benefit amount.
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.
Pro-ration for New Employees	Monthly
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.
Prescription Drug Plan	Prescription Drug expenses are integrated with the medical plan (i.e., subject to medical Deductible and applied towards the medical Out-of-Pocket Limit) and with the Fund (i.e., eligible for reimbursement from the Fund).

PLAN FEATURES	**IN-NETWORK**	**OUT-OF-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)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. 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 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 Applies to all expenses unless otherwise stated.	50%	50%
Payment Limit (per calendar year)	$6,250 Individual $12,500 Family	$20,000 Individual $40,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit.		

PLAN DESIGN & BENEFITS
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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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year Includes routine tests and related lab fees.	Covered 100%; deductible waived	50%; after deductible
Routine Mammograms	Covered 100%; deductible waived	50%; after 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.	Covered 100%; deductible waived	50%; after deductible
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived	50%; after deductible
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	50%; after deductible
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician.	50%; after deductible	50%; after deductible
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
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Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible **Designated Walk-in Clinics** Covered 100%; deductible waived	50%; after deductible
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.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	50%; after deductible	50%; 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	50%; after deductible	50%; 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 Outpatient Complex Imaging	50%; after deductible	50%; 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.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	50%; after deductible	50%; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per year		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per year		
Private Duty Nursing not covered		
Coverage includes nutritional counseling and services of a medical social worker. Reimbursement may not be limited to less than $1,000 per year even if the maximum number of visits has been reached.		
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per year		
Outpatient Short-Term Rehabilitation	50%; after deductible	50%; after deductible
Limited to 20 visits per therapy, per year.		
Includes speech, physical, occupational therapy		
Habilitative Physical Therapy	50%; after deductible	50%; after deductible
Habilitative Occupational Therapy	50%; after deductible	50%; after deductible
Habilitative Speech Therapy	50%; after deductible	50%; after deductible
Autism Behavioral Therapy	50%; after deductible	50%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	50%; after deductible	50%; after deductible
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.

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Infusion Therapy Administered in the home or physician's office	50%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	50%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	50%; after deductible	50%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Advanced Reproductive Technology (ART) 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.	Not Covered	Not Covered
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
90 Day Retail	$30 copay	
Mail Order	$25 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
90 Day Retail	$90 copay	
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Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
90 Day Retail	$150 copay	
Mail Order	$125 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	
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Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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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.

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• 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.
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• 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.

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EXHIBIT 2

Medical and Prescription Experience Reports

Monitoring by Utilization and Enrollment

Company: SCHOOL DISTRICT OF HENDRY CNTY

Group: 51504

Current Paid Period: From 01/2017 to 12/2017

	Enrollment		Premium	Capitation			Fee for Service Claims							
Service Year Month	Contracts	Members	Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
201701	863	1,037	$576,871.64	$0.00	$1,108.50	$1,108.50	$81,620.48	$173,284.69	$100,652.69	$32,825.92	$388,383.78	$70,527.89	$460,020.17	79.74%
201702	863	1,038	$567,850.19	$0.00	$1,106.32	$1,106.32	$37,132.64	$74,387.48	$70,358.55	$35,853.14	$217,731.81	$73,955.99	$292,794.12	51.56%
201703	866	1,043	$572,892.70	$0.00	$1,112.86	$1,112.86	$163,912.46	$119,771.55	$104,792.27	$16,074.48	$404,550.76	$105,278.91	$510,942.53	89.19%
201704	865	1,043	$576,956.84	$0.00	$1,112.86	$1,112.86	$320,686.04	$79,382.43	$81,204.60	$52,026.65	$533,299.72	$98,495.41	$632,907.99	109.70%
201705	864	1,043	$574,857.32	$0.00	$1,112.86	$1,112.86	$278,999.39	$101,264.30	$95,511.10	$23,201.73	$498,976.52	$102,975.02	$603,064.40	104.91%
201706	862	1,036	$572,287.93	$0.00	$1,107.60	$1,107.60	$150,478.77	$196,961.65	$126,701.62	$62,275.87	$536,417.91	$104,814.84	$642,340.35	112.24%
201707	857	1,035	$568,683.37	$0.00	$1,105.42	$1,105.42	$260,230.47	$113,427.80	$101,534.40	$42,470.71	$517,663.38	$105,006.41	$623,775.21	109.69%
201708	782	956	$530,673.76	$0.00	$1,018.22	$1,018.22	$20,812.28	$102,822.59	$90,254.74	$42,411.18	$256,300.79	$83,794.43	$341,113.44	64.28%
201709	829	1,011	$537,358.05	$0.00	$1,077.08	$1,077.08	$66,925.31	$94,391.04	$60,928.68	$28,468.55	$250,713.58	$88,286.43	$340,077.09	63.29%
201710	848	1,032	$580,831.31	$0.00	$1,104.33	$1,104.33	$150,043.45	$77,319.78	$87,648.41	$19,218.38	$334,230.02	$108,358.74	$443,693.09	76.39%
201711	847	1,034	$558,208.66	$0.00	$1,105.16	$1,105.16	$35,333.25	$65,160.95	$79,080.78	$12,728.33	$192,303.31	$90,125.93	$283,534.40	50.79%
201712	842	1,027	$568,523.71	$0.00	$1,096.25	$1,096.25	$19,105.38	$70,235.69	$49,949.07	$15,236.16	$154,526.30	$60,080.30	$215,702.85	37.94%
Total	**10,188**	**12,335**	**$6,785,995.48**	**$0.00**	**$13,167.46**	**$13,167.46**	**$1,585,279.92**	**$1,268,409.95**	**$1,048,616.91**	**$382,791.10**	**$4,285,097.88**	**$1,091,700.30**	**$5,389,965.64**	**79.43%**
Grouping Avg	**637**	**771**	**$424,124.72**	**$0.00**	**$822.97**	**$822.97**	**$99,080.00**	**$79,275.62**	**$65,538.56**	**$23,924.44**	**$267,818.62**	**$68,231.27**	**$336,872.85**	**79.43%**
Monthly Avg	**637**	**771**	**$424,124.72**	**$0.00**	**$822.97**	**$822.97**	**$99,080.00**	**$79,275.62**	**$65,538.56**	**$23,924.44**	**$267,818.62**	**$68,231.27**	**$336,872.85**	**79.43%**

Notes:

- Grand Total includes Medical FFS, Pharmacy FFS and Capitation.
- Enrollment is recast to reflect retroactive adjustments.
- Grouping Avg – Average of the distinct groupings chosen by the user.
- Monthly Avg – Average of a measure over Service/Paid time period.
- FFS = Fee For Service.
- MLR = Medical Loss Ratio.

Monitoring by Utilization and Enrollment

Company: SCHOOL DISTRICT OF HENDRY CNTY

Group: 51504

Current Service Period: From 01/2018 to 12/2018

Current Paid Period: From 01/2018 to 03/2019

	Enrollment		Premium	Capitation				Fee for Service Claims							
Paid Year Month	Contracts	Members	Premium	PCP	Specialty	Total Capitation	Total Incentive	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
201801	847	991	$658,703.37	$0.00	$1,232.41	$1,232.41	$0.00	$19,624.54	$14,418.13	$46,451.88	$20,146.24	$100,640.79	$81,278.23	$183,151.43	27.80%
201802	845	985	$661,978.31	$0.00	$1,212.19	$1,212.19	$0.00	$77,320.08	$87,307.44	$73,365.54	$17,867.29	$255,860.35	$117,546.56	$374,619.10	56.59%
201803	841	979	$650,742.48	$0.00	$1,212.45	$1,212.45	$0.00	$87,655.13	$58,056.02	$101,446.55	$27,151.43	$274,309.13	$108,947.35	$384,468.93	59.08%
201804	836	976	$651,390.14	$0.00	$1,196.64	$1,196.64	$0.00	$67,810.35	$53,822.04	$65,376.64	$20,269.98	$207,279.01	$78,176.92	$286,652.57	44.01%
201805	830	970	$652,077.47	$0.00	$1,203.04	$1,203.04	$0.00	$75,144.26	$29,292.62	$96,089.51	$15,886.48	$216,412.87	$123,963.21	$341,579.12	52.38%
201806	827	964	$643,045.42	$0.00	$1,190.24	$1,190.24	$0.00	$81,797.14	$115,928.80	$69,398.70	$24,055.45	$291,180.09	$107,504.29	$399,874.62	62.18%
201807	824	963	$639,555.79	$0.00	$1,183.84	$1,183.84	$0.00	$119,091.25	$196,479.67	$146,727.84	$27,307.82	$489,606.58	$92,850.00	$583,640.42	91.26%
201808	752	888	$595,717.01	$0.00	$1,100.12	$1,100.12	$0.00	$10,755.22	$157,032.64	$71,684.65	$20,152.25	$259,624.76	$119,699.21	$380,424.09	63.86%
201809	753	891	$587,772.43	$0.00	$1,106.52	$1,106.52	$0.00	$265,330.87	$71,510.61	$59,852.43	$16,804.04	$413,497.95	$95,818.43	$510,422.90	86.84%
201810	821	960	$585,357.11	$0.00	$1,182.94	$1,182.94	$0.00	$162,949.49	$34,891.98	$55,257.76	$32,287.80	$285,387.03	$122,137.05	$408,707.02	69.82%
201811	828	965	$686,234.98	$0.00	$1,195.36	$1,195.36	$0.00	$53,554.68	$79,725.12	$92,398.13	$26,905.15	$252,583.08	$114,841.62	$368,620.06	53.72%
201812	838	978	$657,709.08	$0.00	$1,191.59	$1,191.59	$0.00	$15,932.89	$81,865.12	$132,710.71	$25,342.02	$255,850.74	$102,406.08	$359,448.41	54.65%
201901	0	0	$0.00	$0.00	($2.56)	($2.56)	$0.00	$13,592.64	$120,307.23	$45,993.28	$8,992.43	$188,885.58	$40,625.47	$229,508.49	0.00%
201902	0	0	$0.00	$0.00	$1.28	$1.28	$0.00	$38,033.00	$15,897.28	$1,322.14	$3,559.03	$58,811.45	$120.15	$58,932.88	0.00%
201903	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,206.71	$1,364.79	$410.90	$4,982.40	$0.00	$4,982.40	0.00%
Total	**9,842**	**11,510**	**$7,670,283.59**	**$0.00**	**$14,206.06**	**$14,206.06**	**$0.00**	**$1,088,591.54**	**$1,119,741.41**	**$1,059,440.55**	**$287,138.31**	**$3,554,911.81**	**$1,305,914.57**	**$4,875,032.44**	**63.56%**
Grouping Avg	**656**	**767**	**$511,352.24**	**$0.00**	**$947.07**	**$947.07**	**$0.00**	**$72,572.77**	**$74,649.43**	**$70,629.37**	**$19,142.55**	**$236,994.12**	**$87,060.97**	**$325,002.16**	**63.56%**
Monthly Avg	**656**	**767**	**$511,352.24**	**$0.00**	**$947.07**	**$947.07**	**$0.00**	**$72,572.77**	**$74,649.43**	**$70,629.37**	**$19,142.55**	**$236,994.12**	**$87,060.97**	**$325,002.16**	**63.56%**

Notes:

- Grand Total includes Medical FFS, Pharmacy FFS, Incentives and Capitation.
- Grouping Avg – Average of the distinct groupings chosen by the user.
- Monthly Avg – Average of a measure over Service/Paid time period.
- Enrollment is recast to reflect retroactive adjustments.
- FFS = Fee For Service.
- MLR = Medical Loss Ratio.

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SCHOOL BOARD OF HENDRY COUNTY FLORIDA

Group/Control#: 00109695

Experience Exhibit

- Claims displayed are incurred and completed through December 2019.
- Claims displayed are based on a rolling 12 months of data.
- Claims paid through February 2020.

Monthly Claims:

Month	Subscribers	Members	Monthly Billed Premium	Total Medical FFS/Caps	Total Rx Claims	AHF Fund Payments (Included in Totals) Medical	AHF Fund Payments (Included in Totals) Pharmacy
January 2019	864	1,025	$637,090	$381,117	$65,072	$3,447	$559
February 2019	861	1,021	$631,928	$239,987	$127,739	$3,450	$1,069
March 2019	866	1,032	$637,931	$397,383	$148,661	$1,853	$862
April 2019	866	1,030	$639,208	$371,136	$161,408	$748	$282
May 2019	869	1,029	$636,790	$352,494	$182,236	$1,357	$308
June 2019	843	998	$618,460	$540,866	$141,873	$1,837	$309
July 2019	833	988	$610,712	$395,940	$217,204	$980	$96
August 2019	773	912	$568,109	$253,701	$163,482	$2,151	$190
September 2019	772	914	$567,555	$422,219	$118,569	$2,708	$268
October 2019	862	1,013	$632,701	$374,359	$203,666	$1,654	$127
November 2019	864	1,012	$632,973	$299,586	$137,072	$423	$68
December 2019	865	1,013	$634,792	$374,667	$159,369	$803	$321

Aggregate Premium Billed	$7,448,249
Aggregate Incurred Claims	$6,229,809
Cost Ratio	84%

Premium amounts and lives counts displayed on this report are unaudited

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SCHOOL BOARD OF HENDRY COUNTY FLORIDA

Group/Control#: 00109695

Experience Exhibit

- Claims displayed are incurred and completed through December 2020.
- Claims displayed are based on a rolling 12 months of data.
- Claims paid through February 2021.

Monthly Claims:

Month	Subscribers	Members	Monthly Billed Premium	Total Medical FFS/Caps	Total Rx Claims	AHF Fund Payments (Included in Totals) Medical	Pharmacy
January 2020	891	1,046	$671,819	$317,650	$171,053	$3,435	$822
February 2020	891	1,042	$669,430	$314,816	$123,165	$620	$1,559
March 2020	890	1,042	$669,430	$531,537	$192,675	$1,444	$418
April 2020	892	1,046	$671,401	$239,793	$176,663	$169	$325
May 2020	888	1,040	$667,746	$318,321	$152,663	$522	$326
June 2020	863	1,017	$651,485	$443,113	$187,501	$165	$154
July 2020	857	1,009	$647,518	$435,205	$211,740	$464	$151
August 2020	814	965	$614,915	$321,006	$175,016	$321	$272
September 2020	811	966	$614,385	$343,103	$201,862	$1,168	$148
October 2020	878	1,043	$661,512	$608,431	$181,894	$1,620	$105
November 2020	875	1,037	$658,001	$828,792	$186,373	$1,311	$315
December 2020	882	1,043	$662,921	$459,078	$210,106	$1,379	$191

Aggregate Premium Billed	$7,860,562
Aggregate Incurred Claims	$7,331,557
Cost Ratio	93%

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The months of March, 2020 and forward may show lower claims amounts than the average claim month due to the COVID 19 pandemic. These months may not be reflective of normal utilization patterns and we do not recommend using these months in projecting future utilization" Medical and dental utilization began to return to normal levels in June and July. We expect utilization in the second half of the year to remain at these levels with some regions continuing to be affected by COVID-19 waves.

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SCHOOL BOARD OF HENDRY COUNTY FLORIDA

Group/Control#: 00109695

Experience Exhibit

- Claims displayed are incurred and completed through September 2021.
- Claims displayed are based on a rolling 12 months of data.
- Claims paid through November 2021.

Monthly Claims:

Month	Subscribers	Members	Monthly Billed Premium	Total Medical FFS/Caps	Total Rx Claims	AHF Fund Payments (Included in Totals) Medical	AHF Fund Payments (Included in Totals) Pharmacy
October 2020	878	1,043	$661,512	$593,812	$181,894	$1,620	$105
November 2020	874	1,034	$656,683	$641,341	$186,373	$850	$315
December 2020	881	1,040	$661,602	$464,099	$210,139	$1,231	$191
January 2021	934	1,085	$440,941	$533,773	$194,094	$6,535	$892
February 2021	920	1,072	$730,756	$349,850	$181,860	$3,135	$417
March 2021	934	1,086	$740,920	$382,470	$164,650	$1,623	$505
April 2021	948	1,099	$752,930	$358,621	$193,979	$2,422	$92
May 2021	942	1,096	$748,915	$625,356	$196,259	$3,994	$473
June 2021	899	1,055	$717,129	$462,789	$235,905	$3,305	$152
July 2021	876	1,023	$698,882	$623,009	$193,244	$933	$759
August 2021	823	968	$658,071	$929,167	$189,768	$1,976	$52
September 2021	820	961	$656,604	$459,941	$186,153	$495	$38

Aggregate Premium Billed	$8,124,944
Aggregate Incurred Claims	$8,738,547
Cost Ratio	108%

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The months of March 2020 and forward may show lower claim amounts than the average claim month due to the COVID-19 pandemic. These months may not be reflective of normal utilization patterns, and we do not recommend using these months in projecting future utilization. Medical and dental utilization began to return to normal levels in June and July. We expect utilization in the second half of the year to remain at these levels with some regions continuing to be affected by COVID-19 waves

SCHOOL BOARD OF HENDRY COUNTY FLORIDA

Large Claim Listing

Policyholder Number - 109695
Group Number - 109695

- This report is designed to meet your need for data in evaluating your benefit plan. We have removed individual member identifiers (e.g., name, ID number, etc.) because most plan sponsors find that their needs can be met without identifiers and also to comply with state and federal health information privacy regulations.
- Amounts below reflect Medical and RX costs.

Total Group

Claimants with over $25,000 in claims for 10/1/2020 - 9/30/2021

Claimant	Total	ICD-10 Code Description
Claimant 1	$200,974	Secondary Malignant Neoplasm Of Retroperitoneum And Peritoneum
Claimant 2	$197,048	Non-st Elevation (nstemi) Myocardial Infarction
Claimant 3	$193,286	Partial Traumatic Amputation At Knee Level, Right Lower Leg, Initial Encounter
Claimant 4	$185,719	Unspecified Urethral Stricture, Male, Unspecified Site
Claimant 5	$174,988	Restricted Diagnosis
Claimant 6	$169,827	Noninfective Gastroenteritis And Colitis, Unspecified
Claimant 7	$155,668	Atypical Atrial Flutter
Claimant 8	$153,958	Non-st Elevation (nstemi) Myocardial Infarction
Claimant 9	$152,384	Displaced Bimalleolar Fracture Of Right Lower Leg, Initial Encounter For Closed Fracture
Claimant 10	$128,698	Restricted Diagnosis
Claimant 11	$126,820	Malignant Neoplasm Of Overlapping Sites Of Right Bronchus And Lung
Claimant 12	$117,493	Thrombosis Due To Vascular Prosthetic Devices, Implants And Grafts, Initial Encounter
Claimant 13	$114,304	Infection Following A Procedure, Deep Incisional Surgical Site, Initial Encounter
Claimant 14	$109,573	Diverticulitis Of Large Intestine With Perforation And Abscess Without Bleeding
Claimant 15	$107,830	Chronic Inflammatory Demyelinating Polyneuritis
Claimant 16	$101,653	Encounter For Screening For Malignant Neoplasm Of Colon
Claimant 17	$96,749	Hypertensive Emergency
Claimant 18	$90,611	Supraventricular Tachycardia
Claimant 19	$89,698	Contusion Of Scalp, Initial Encounter
Claimant 20	$88,828	Multiple Sclerosis
Claimant 21	$87,252	Restricted Diagnosis
Claimant 22	$84,475	Encounter For Screening For Malignant Neoplasm Of Colon

SCHOOL BOARD OF HENDRY COUNTY FLORIDA

Large Claim Listing

Policyholder Number - 109695
Group Number - 109695

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Total Group

Claimants with over $25,000 in claims for 10/1/2020 - 9/30/2021

Claimant	Total	ICD-10 Code Description
Claimant 23	$82,294	Multiple Sclerosis
Claimant 24	$81,626	Malignant Neoplasm Of Overlapping Sites Of Left Female Breast
Claimant 25	$73,758	Cutaneous Abscess Of Left Foot
Claimant 26	$72,417	Epigastric Pain
Claimant 27	$72,104	Radiculopathy, Lumbar Region
Claimant 28	$71,677	Rheumatoid Arthritis, Unspecified
Claimant 29	$71,369	Encounter For Sterilization
Claimant 30	$70,540	Other Specified Sepsis
Claimant 31	$68,659	Disease Of Intestine, Unspecified
Claimant 32	$67,498	Panic Disorder Episodic Paroxysmal Anxietyy
Claimant 33	$67,395	Unilateral Primary Osteoarthritis, Left Hip
Claimant 34	$64,724	Encounter For Screening Mammogram For Malignant Neoplasm Of Breast
Claimant 35	$60,685	Hepatic Failure, Unspecified Without Coma
Claimant 36	$55,009	Sepsis Due To Escherichia Coli (e. Coli)
Claimant 37	$54,472	Paroxysmal Atrial Fibrillation
Claimant 38	$52,484	Non-st Elevation (nstemi) Myocardial Infarction
Claimant 39	$49,154	Covid-19
Claimant 40	$48,122	Unilateral Primary Osteoarthritis, Right Hip
Claimant 41	$47,167	Restricted Diagnosis
Claimant 42	$45,460	Ischemic Cardiomyopathy
Claimant 43	$44,934	Paroxysmal Atrial Fibrillation
Claimant 44	$44,621	Contact With And (suspected) Exposure To Other Viral Communicable Diseases
Claimant 45	$44,154	Sepsis, Unspecified Organism

SCHOOL BOARD OF HENDRY COUNTY FLORIDA

Large Claim Listing

Policyholder Number - 109695
Group Number - 109695

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- Amounts below reflect Medical and RX costs.

Total Group

Claimants with over $25,000 in claims for 10/1/2020 - 9/30/2021

Claimant	Total	ICD-10 Code Description
Claimant 46	$42,625	Supraventricular Tachycardia
Claimant 47	$42,368	Restricted Diagnosis
Claimant 48	$41,678	Calculus Of Gallbladder Without Cholecystitis Without Obstruction
Claimant 49	$39,203	Restricted Diagnosis
Claimant 50	$38,469	Paroxysmal Atrial Fibrillation
Claimant 51	$37,794	Migraine With Aura, Not Intractable, Without Status Migrainosus
Claimant 52	$37,643	Sensorineural Hearing Loss, Bilateral
Claimant 53	$37,569	Other Synovitis And Tenosynovitis, Left Hand
Claimant 54	$35,520	Unilateral Primary Osteoarthritis, Right Knee
Claimant 55	$34,246	Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris
Claimant 56	$33,497	Unilateral Primary Osteoarthritis, Right Hip
Claimant 57	$30,534	Atherosclerotic Heart Disease Of Native Coronary Artery With Other Forms Of Angina Pectoris
Claimant 58	$30,532	Covid-19
Claimant 59	$30,253	Restricted Diagnosis
Claimant 60	$29,966	Restricted Diagnosis
Claimant 61	$29,656	Idiopathic Urticaria
Claimant 62	$27,494	Hypertensive Encephalopathy
Claimant 63	$27,230	Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris
Claimant 64	$26,721	Calculus Of Gallbladder With Chronic Cholecystitis Without Obstruction
Claimant 65	$25,862	Unilateral Primary Osteoarthritis, Left Knee
Claimant 66	$25,695	Serous Retinal Detachment, Right Eye
Claimant 67	$25,632	Restricted Diagnosis

SCHOOL BOARD OF HENDRY COUNTY FLORIDA

Large Claim Listing

Policyholder Number - 109695
Group Number - 109695

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- Amounts below reflect Medical and RX costs.

Total Group

Claimants with over $25,000 in claims for 10/1/2020 - 9/30/2021

Claimant	Total	ICD-10 Code Description
Claimant 68	$25,504	Encounter For Screening For Malignant Neoplasm Of Colon
Claimant 69	$25,373	Covid-19

The months of March 2020 and forward may show lower claim amounts than the average claim month due to the COVID-19 pandemic. These months may not be reflective of normal utilization patterns, and we do not recommend using these months in projecting future utilization. Medical and dental utilization began to return to normal levels in June and July. We expect utilization in the second half of the year to remain at these levels with some regions continuing to be affected by COVID-19 waves

SCHOOL BOARD OF HENDRY COUNTY FLORIDA - 100252625
Group Number(s): 109695

COVID All-Time Experience: Jan 2020 - Dec 2021, paid through December 2021

Year Over Year Results:
Prior: Jan - Dec 2020, paid through December 2020
Current: Jan - Dec 2021, paid through December 2021

Why use this report?

Gain a deeper understanding of the impacts from the COVID pandemic.

This detailed Monthly Analytic Report provides insights into the following key areas:

- COVID-19 specific claim activity
- Telemedicine volumes and impact
- Risk profile for severe illness based on CDC guidance
- Counties that have high or emerging levels of COVID-19
- COVID-19 vaccinations

This data can help you more fully explore the types of services and population being impacted during the pandemic and will help you answer your key questions such as:

- How many members have evidence of the condition or been tested?
- How many hospitalizations have there been?
- How many people have been vaccinated?
- Where are people seeking care?
- What is the demand and utilization for telehealth services?
- What is the higher risk for severe illness profile within this population? What is the risk profile for employees specifically?

Things to consider when reviewing this data

Reporting is based on diagnosis and procedure codes that are billed on a claim

Standard codes and coding guidance have rapidly evolved throughout the pandemic. While healthcare institutions adjust to new codes and coding changes, claims may be understated based on:

- Provider variance in understanding billing guidance
- Inability to confirm diagnosis due to testing limitations

- Test results received by provider post-claim submission
- No claim submission (e.g., testing covered by public health entity or inpatient)

- Claim submission prior to the introduction of COVID-19 specific ICD-10 codes
- COVID-19 vaccine administration information included in this report represents claims covered under the Aetna medical or Aetna pharmacy benefits. International claims may not be billed and processed in accordance with the coding and definitions used in this report and may impact the data/results shown.
- Data in this report is compiled at the group number level. Member movement between group numbers may impac aggregate claimant counts.

What codes are used in the COVID monthly view?

The following diagnoses and procedures are used to identify likely COVID-19 related claims in this report. **These codes represent our current best efforts to identify likely COVID-19 activity.** References to COVID-19 in this report are based on the codes below, some of which are not COVID-specific.

COVID-19- Specific Diagnosis and Related Codes - These are codes that are specific to COVID-19 related illness:
U07.1 - COVID-19 confirmed cases - Data is included when this code is billed as the primary, secondary or tertiary diagnosis
J12.82 - Pneumonia due to COVID-19 (new 1/1/2021)
M35.81 - Multi-inflammatory syndrome (new 1/1/2021)
M35.89 - Other specified systemic involvement of connective tissue (new 1/1/2021)

Coronavirus Diagnosis Codes - Providers were guided to bill these in the initial outbreak:
B97.29 - Other coronavirus as the cause of diseased
B34.2 - Coronavirus infection, unspecified

Exposure Diagnosis Codes - Pre-existing and new codes used for COVID-19 exposure and non-confirmed/non-presumptive cases. Because these codes may also be used for suspected exposure to other biological agents and viral communicable diseases, some claims may be for non-COVID related cases:
Z03.818 - Suspected exposure to other biological agents ruled out
Z20.828 - Exposure to other viral communicable diseases
Z20.822 - Contact with and (suspected) exposure to COVID-19 (new 1/1/2021)

Encounter Diagnosis Code - New code introduced specifically for visits related to COVID screenings:
Z11.52 - Encounter for screening for COVID-19- (new 1/1/2021)

Testing Procedure Codes - Used to identify COVID-19 and antibody testing: **86328, 86408, 86409, 86413, 86769, 87426, 87428, 87635, 87636, 87637, 87811, C9803, G2023, G2024, U0001, U0002, U0003, U0004, U0005, 0202U, 0223U, 0224U, 0225U, 0226U, 0240U, 0241U**

Vaccination Administration Procedure / NDC Codes - Used to identify COVID-19 vaccination administration. The actual vaccine cost is being paid by the federal government; data in this report represents administration cost / utilization: **0001A,0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0031A, 0034A, 0064A and NDCs 59267100001, 59267100002, 59267100003, 80777027310, 80777027399, 80777027398, 80777027315, 59676058005, 59676058015.**

Telemedicine - Metrics include Teladoc as well as community based providers performing approved telemedicine services.

Report terms

Here are more specific details behind terms used in this report:

Claimant Distribution Definitions:

- **Confirmed Cases -** The number of members who had a claim with the COVID-19 specific diagnosis code U07.1 billed as one of the first 3 diagnoses on a claim or had a claim with J12.82, M35.81 or M35.89 as a primary diagnosis

- **Probable Cases** - The number of members who have either of the general coronavirus codes shown on the left (B97.29 or B34.2) billed as the primary diagnosis on a claim

- **Exposure Cases** - The number of members who have any of the 3 exposure diagnosis codes shown on the left (Z03.818, Z20.828, Z20.822) billed as the primary diagnosis on a claim

- **Lab Test, Vaccine or Encounter Only Cases** - The number of members who had a lab test with a diagnosis code other than those identified above or only had evidence of an encounter for screening (Z11.52) or a vaccination with no other diagnosis codes used in this report. These members have ONLY had claims for testing, screening encounters or vaccines and do not have other claims that fit the criteria outlined above

High Risk Members - We used the CDC guidance to identify members within the population that may be at higher risk for severe illness. This includes members who are over 64 as well as those that have one or more conditions outlined by the CDC such as serious heart conditions, diabetes, chronic kidney disease, etc. The CDC guidance can be found here: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html. Customers new to Aetna 1/1/2021 will not have condition-based risk data populated until there is sufficient information to identify disease states.

Time Periods - There are 2 time periods used in this report:

- **COVID All-Time Experience** represents incurred claims for COVID-related expenses from January 1, 2020 through the most recent incurred month

- **Year Over Year Experience (Current and Prior)** represents 2021 and 2020 incurred claims for the dates shown at the top of this report. The claim lag for both time periods is the same to provide a consistent year over year comparison.

Section I
COVID-19 Population Alerts

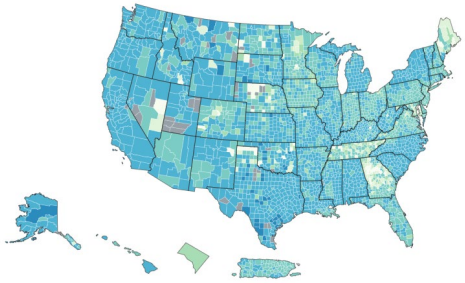
COVID-19 population alerts

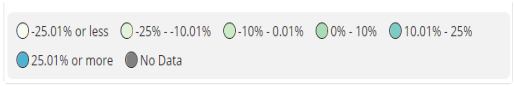
Hot Spots In the United States - Map (to the right)
The map shows how the number of new cases have CHANGED in the last two weeks across the U.S. (not plan sponsor-specific). This provides an indication of which direction the level of new cases is trending.

County Alerts (below)
The tables below show the average daily new cases per 100,000 individuals by county over the past 7 days . These rates are reflective of the overall population of the county, not of your specific membership. This data is to highlight where you have membership in counties experiencing high or emerging rates of new cases.

We use information collected by the CDC to calculate a '7 day average new case count.' This data is normalized for population size (new cases per 100,000 individuals) to smooth unusual daily highs or lows, caused by data collection fluctuations.

The data below is for your top 25 counties (by membership) that are identified as having either a high or emerging average daily case rates. There could be less than 25 counties in the tables (or none) if the alert criteria is not met.





Heat map of recent growth by county: This map shows the average growth between the last seven days and the previous seven days. Darker colors indicate an increasing trend while lighter colors indicate a decreasing trend.
Last Updated: 01/08/2022 | Source: CDC

High risk counties (red) had greater than 25 daily new cases per 100,000 individuals
Emerging risk counties (orange) had between 10 and 25 daily new cases per 100,000 individuals

Data is for week ending:
01/09/2022

Note: Counties with less than 20 new cases in the prior week will not appear in this report. New case data is not available for approximately 30 counties. "Your members" represents your total commercial Aetna self-insured membership.

High Risk (>=25 new cases per 100,000 individuals)

State, County	County population	Your members	Avg daily new cases per 100K
Florida, Hendry	42,022	831	232.9
Florida, Lee	770,577	97	196.7
Florida, Glades	13,811	47	77.6
Florida, Palm Beach	1,496,770	12	278.2
Florida, Charlotte	188,910	11	121.0
Florida, Collier	384,902	5	180.5
Florida, Sumter	132,420	2	88.8
North Dakota, Cass	181,923	2	194.6
Florida, Highlands	106,221	2	127.9
Florida, Alachua	269,043	2	200.6
Indiana, Delaware	114,135	1	110.8
Florida, Okeechobee	42,168	1	201.9
North Carolina, Rutherford	67,029	1	84.8
Florida, Hillsborough	1,471,968	1	214.6
Tennessee, Dickson	53,948	1	75.2
Georgia, Gwinnett	936,250	1	138.6
Florida, Miami-Dade	2,716,940	1	580.7

Emerging Risk (10-24 new cases per 100,000 individuals)

State, County	County population	Your members	Avg daily new cases per 100K
No emerging risk counties			

Section II
All-Time COVID-19 Experience

Time period: Claims incurred Jan 2020 - Dec 2021, paid through December 2021

At a glance

COVID-19 All-time experience

Average Members: 1,032

Time period: Jan 2020 - Dec 2021, paid through December 2021

Key Statistics (Medical Claims Only)

$455,665	562
Medical Paid	Claimants

More detailed information is found on the next page to help you answer critical questions:

- ✓ *How is COVID-19 impacting our health care spend? What is the context of trends and spend distribution across cost categories?*
- ✓ *How many members are affected?*
- ✓ *How many claims-based tests have been conducted for the virus and antibodies?*
- ✓ *How many individuals have received vaccinations?*
- ✓ *How is COVID spend trending in 2021 compared to 2020?*

Additional views and detailed data tables following the main report also provide specific cost and utilization metrics across age band categories as well as service categories

*Claimant Distribution**

how your total claimants break down based on diagnosis code information

152	**$363,413**	**Confirmed**
5	$696	Probable
322	$82,969	Exposure
83	$8,588	Lab test, screening encounter or vaccine only

**refer to Report terms on page 1*

*COVID-19 population risk**

38.5%

Members at risk for severe illness

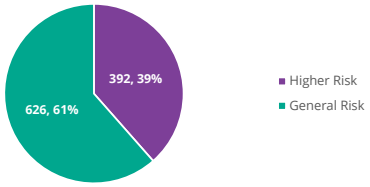
General risk for contracting COVID-19 exists across the population. Age and underlying health conditions are associated with higher risk for severe illness with the potential for severe symptoms, hospitalizations, ICU services, and poorer outcomes.

The pie chart shows the number and percent of your population with CDC-identified "higher risk for severe illness" factors.

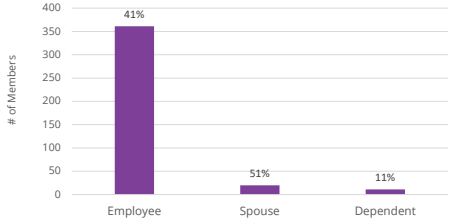
The bar chart displays this information by member type.

** See page one for High Risk definition.*

Population risk for severe illness



Higher risk for severe illness, by member type



Testing

$71,789	465	756	24
Total Paid - All Tests	Unique Claimants	# of Viral Tests	#of Antibody Tests

*Vaccine Administration (Medical & Pharmacy)**

$17,927	288	Unique Claimants 183	14.57%
Total Paid for Vaccine Administration	Members with a Vaccination	Members Fully Vaccinated**	% Fully Vaccinated

*Includes claims paid under the Aetna Pharmacy benefit plan if applicable
**The unique count of members => 5 years of age who have received all of the required doses based on claims received

COVID-19 All-time experience details

Time period: Jan 2020 - Dec 2021, paid through December 2021

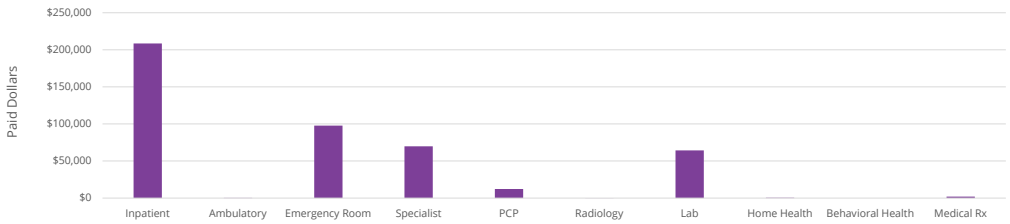
Average Members: 1,032

COVID-19 Cost Detail Breakdown (Medical Claims Only)

$455,665

represents COVID-related claims for **562**

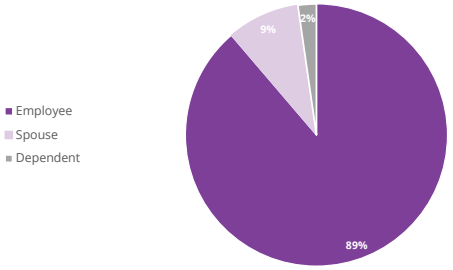
unique claimants across these medical cost categories:



Spotlight on specific categories

7	89	65
Admissions	Visits	Visits
Inpatient	**Emergency Room**	**Telemedicine**
Paid	Paid	Paid
$208,587	**$97,777**	**$3,994**

Percent Paid by Member Type



*Claimant distribution - All Members**

how your total medical claimants break down based on diagnosis code

152	$363,413	**Confirmed**
5	$696	Probable
322	$82,969	Exposure
83	$8,588	Lab test, screening encounter or vaccine only

*refer to Report terms on page 1

*Claimant distribution - Employees**

how your total claimants break down based on diagnosis code information

147	$326,284	**Confirmed**
5	$696	Probable
286	$70,266	Exposure
70	$7,124	Lab test, screening encounter or vaccine only

*refer to Report terms on page 1

*Claimant distribution - Spouse & Dependents**

how your total claimants break down based on diagnosis code information

5	$37,128	**Confirmed**
0	$0	Probable
36	$12,703	Exposure
13	$1,464	Lab test, screening encounter or vaccine only

*refer to Report terms on page 1

COVID-19 All-time experience - Testing and Vaccination

Average Members: 1,032

Time period: Jan 2020 - Dec 2021, paid through December 2021

COVID-19 testing

$71,789
Total Paid - All Tests

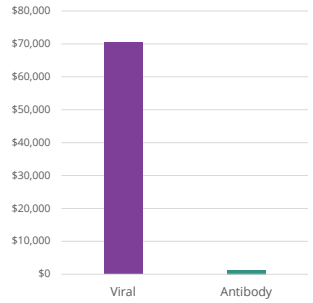
16%
Testing as a % of Total COVID Spend

465
Claimants

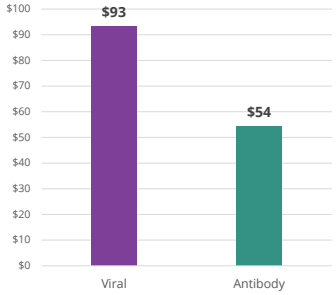
756
# of Viral Tests

24
# of Antibody Tests

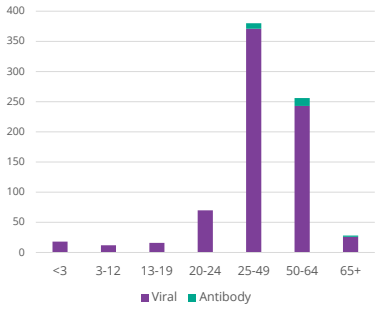
Paid by COVID Test Type



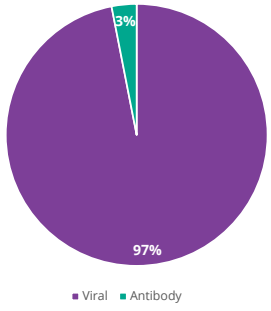
Average Cost per Test



of Tests by Age Band



of Tests



COVID-19 Vaccine Administration (Medical & Pharmacy)

$17,927
Total Paid for Vaccine Administration

183
Fully Vaccinated Members

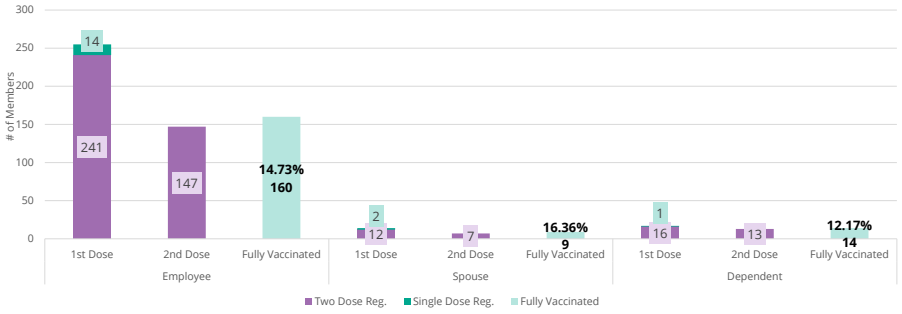
14.57%

Unique Claimants

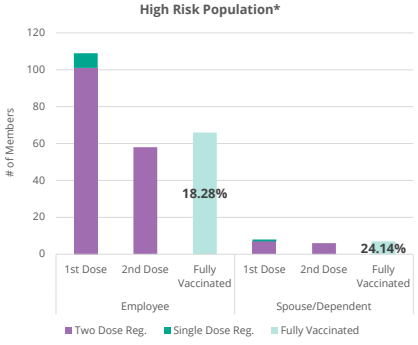
Two Dose Regimen		Single Dose Regimen
269	**167**	**17**
First Dose	Second Dose	

Booster Shot: **38**

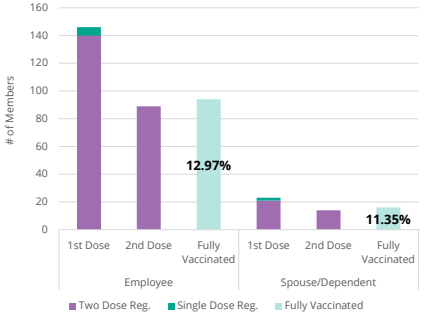
Vaccinations by Member Type



High Risk Population*



General Risk Population



** See page one for High Risk definition*

Section III
Year Over Year Results

Current period: Claims incurred Jan - Dec 2021, paid through December 2021

Prior period: Claims incurred Jan - Dec 2020, paid through December 2020

COVID experience - year over year

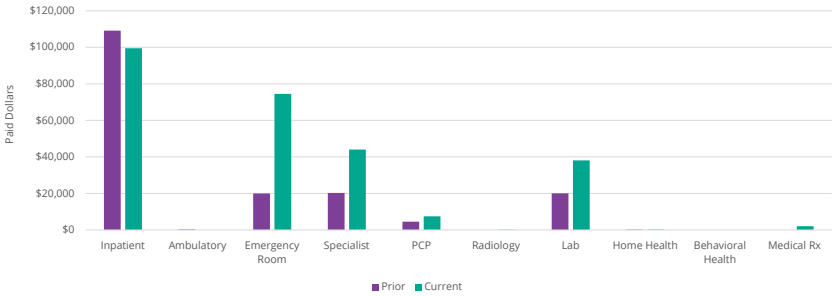
Average Current Members: 1,040

Current period: Claims incurred Jan - Dec 2021, paid through December
Prior period: Claims incurred Jan - Dec 2020, paid through December 2020

COVID-19 Cost Detail Breakdown (Medical Claims Only)

$265,975

represents 2021 COVID-related claims for **405** *unique claimants across these medical cost categories:*



Current period spotlight on specific categories

3	59	$2,070
Admissions **Inpatient** Paid	Visits **Emergency Room** Paid	Medical Paid **Vaccine Administration** Pharmacy* Paid
$99,470	**$74,481**	**$15,857**

**For Aetna Pharmacy Benefit plans.*

How is the impact of COVID-19 changing year over year?

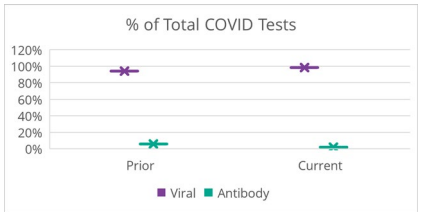
+50.2%	+68.0%
COVID PMPM Trend	Change in # of Unique Claimants

Testing

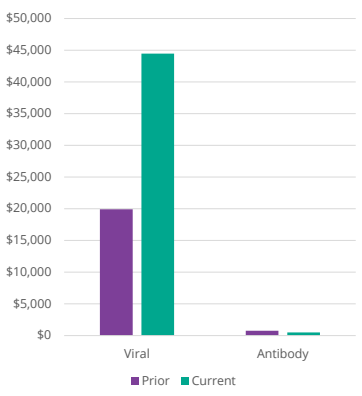
$44,970	308	450	8
Total Paid - All Tests	Unique Claimants	# of Viral Tests	# of Antibody Tests
Change **+117%**	**+57%**	**+87%**	**-47%**

17%

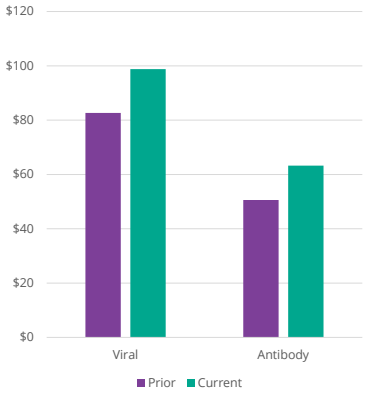
Testing as a % of Total COVID Spend



Paid by COVID Test Type



Average Cost per COVID Test



Telemedicine experience - year over year

Average Current Members: 1,040

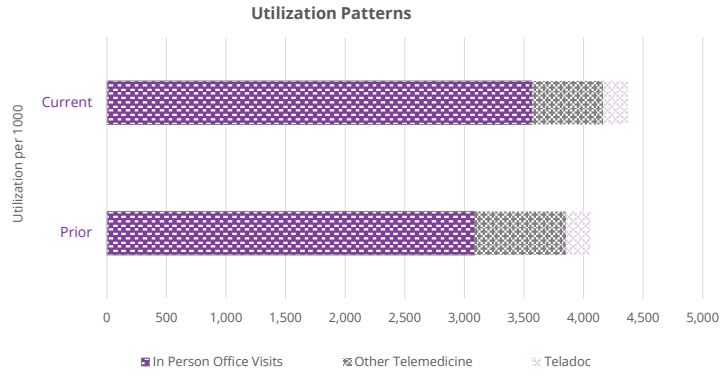
Current period: Claims incurred Jan - Dec 2021, paid through December

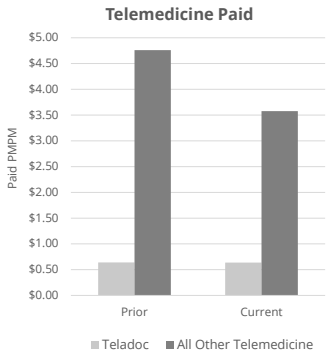
Prior period: Claims incurred Jan - Dec 2020, paid through December 2020

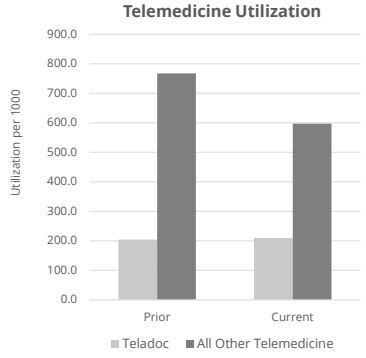
Telemedicine

What is this population's telemedicine utilization and how has it changed?

$52,604	839	313
-21%	-16%	-16%
Paid	Total Visits	Claimants



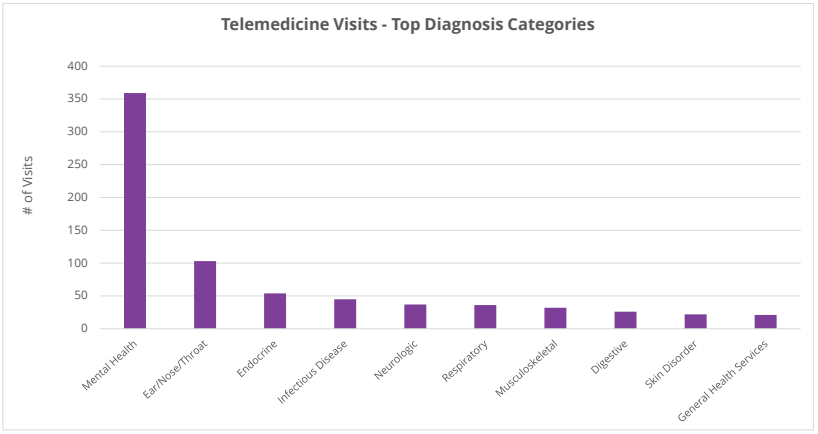


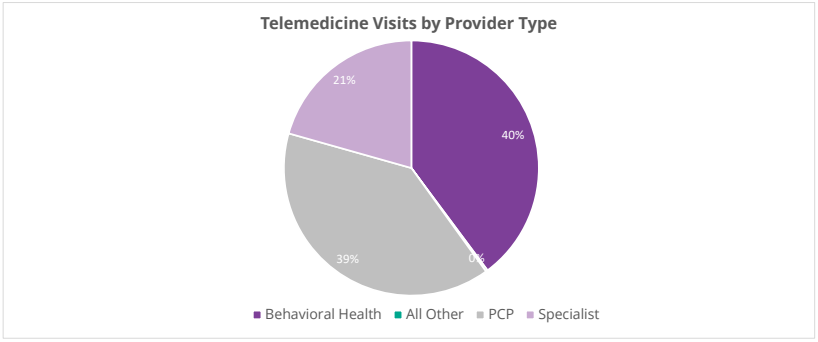


How telemedicine is being used in the context of the pandemic

Changes in the use of telemedicine services are an immediate observable side effect of the pandemic. Stay at home orders and social distancing resulted in many healthcare providers ceasing non-emergent office visits and providing them virtually via secured technology. This change in practice has and will result in large increases in telemedicine utilization with expected decreases in office-based utilization.

Why is this population turning to telemedicine?





Section IV
Appendix

Data tables - year over year COVID trends

Current period: Claims incurred Jan - Dec 2021, paid through December 2021
Prior period: Claims incurred Jan - Dec 2020, paid through December 2020

# of Members at risk by state

COVID-19 alerts - top 50 counties with highest and emerging risk

Vaccination summary by state

COVID trends - year over year

Table 1: Total COVID-19 Medical Cost and Utilization:

	# of Unique Claimants			Medical Paid			Medical Paid PMPM			Visits			Visits per 1,000			Cost per Visit		
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	4	6	50.0%	$259	$1,717	563.0%	$0.02	$0.14	552.8%	5	18	260.0%	4.9	17.3	254.5%	$52	$95	84.2%
3 - 12 years	1	6	500.0%	$82	$2,889	3,404.0%	$0.01	$0.23	3,350.4%	1	21	2,000.0%	1.0	20.2	1,967.9%	$82	$138	66.9%
13 - 19 years	4	9	125.0%	$956	$1,635	71.0%	$0.08	$0.13	68.4%	7	16	128.6%	6.8	15.4	125.1%	$137	$102	-25.2%
20 - 24 years	22	27	22.7%	$5,241	$4,704	-10.2%	$0.43	$0.38	-11.6%	53	64	20.8%	51.7	61.5	18.9%	$99	$74	-25.7%
25 - 49 years	108	222	105.6%	$31,829	$216,869	581.4%	$2.59	$17.38	570.9%	185	561	203.2%	180.6	539.4	198.6%	$172	$387	124.7%
50 - 64 years	95	120	26.3%	$134,544	$28,577	-78.8%	$10.95	$2.29	-79.1%	244	263	7.8%	238.2	252.9	6.1%	$551	$109	-80.3%
65+ years	7	15	114.3%	$1,486	$9,584	545.0%	$0.12	$0.77	535.1%	12	40	233.3%	11.7	38.5	228.2%	$124	$240	93.5%
Total	**241**	**405**	**68.0%**	**$174,397**	**$265,975**	**52.5%**	**$14.19**	**$21.31**	**50.2%**	**507**	**983**	**93.9%**	**495.0**	**945.1**	**90.9%**	**$344**	**$271**	**-21.3%**

Table 2: COVID-19 Viral Testing

	# of Unique Claimants			# of Tests			Medical Paid Amount			Medical Paid PMPM			Cost per Test		
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	2	6	200.0%	3	14	366.7%	$124	$1,462	1,078.9%	$0.01	$0.12	1,060.8%	$41	$104	152.6%
3 - 12 years	0	5	-	0	11	-	$0	$1,342	-	$0.00	$0.11	-	$0	$122	-
13 - 19 years	4	6	50.0%	4	9	125.0%	$357	$931	160.6%	$0.03	$0.07	156.6%	$89	$103	15.8%
20 - 24 years	21	20	-4.8%	31	32	3.2%	$2,083	$2,599	24.8%	$0.17	$0.21	22.9%	$67	$81	20.9%
25 - 49 years	76	169	122.4%	98	243	148.0%	$8,554	$23,652	176.5%	$0.70	$1.90	172.3%	$87	$97	11.5%
50 - 64 years	78	85	9.0%	99	122	23.2%	$8,270	$12,428	50.3%	$0.67	$1.00	48.0%	$84	$102	21.9%
65+ years	5	14	180.0%	6	19	216.7%	$536	$2,049	282.1%	$0.04	$0.16	276.2%	$89	$108	20.7%
Total	**186**	**305**	**64.0%**	**241**	**450**	**86.7%**	**$19,924**	**$44,463**	**123.2%**	**$1.62**	**$3.56**	**119.7%**	**$83**	**$99**	**19.5%**

Table 2a: COVID-19 Antibody Testing

	# of Unique Claimants			# of Tests			Medical Paid Amount			Medical Paid PMPM			Cost per Test		
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	0	0	-	0	0	-	$0	$0	-	$0.00	$0.00	-	$0	$0	-
3 - 12 years	0	0	-	0	0	-	$0	$0	-	$0.00	$0.00	-	$0	$0	-
13 - 19 years	0	0	-	0	0	-	$0	$0	-	$0.00	$0.00	-	$0	$0	-
20 - 24 years	0	0	-	0	0	-	$0	$0	-	$0.00	$0.00	-	$0	$0	-
25 - 49 years	6	3	-50.0%	6	3	-50.0%	$303	$127	-58.0%	$0.02	$0.01	-58.7%	$50	$42	-16.1%
50 - 64 years	7	5	-28.6%	7	5	-28.6%	$330	$379	14.9%	$0.03	$0.03	13.2%	$47	$76	60.9%
65+ years	2	0	-100.0%	2	0	-100.0%	$126	$0	-100.0%	$0.01	$0.00	-100.0%	$63	$0	-100.0%
Total	**15**	**8**	**-46.7%**	**15**	**8**	**-46.7%**	**$759**	**$506**	**-33.3%**	**$0.06**	**$0.04**	**-34.3%**	**$51**	**$63**	**25.0%**

Table 3: COVID-19 Vaccinations (Medical)

	# of Unique Claimants			# of Vaccinations			Medical Paid Amount			Medical Paid PMPM			Cost per Vaccination		
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	0	0	-	0	0	-	$0	$0	-	$0.00	$0.00	-	$0	$0	-
3 - 12 years	0	0	-	0	0	-	$0	$0	-	$0.00	$0.00	-	$0	$0	-
13 - 19 years	0	1	-	0	1	-	$0	$40	-	$0.00	$0.00	-	$0	$40	-
20 - 24 years	0	2	-	0	3	-	$0	$149	-	$0.00	$0.01	-	$0	$50	-
25 - 49 years	0	14	-	0	22	-	$0	$832	-	$0.00	$0.07	-	$0	$38	-
50 - 64 years	0	18	-	0	31	-	$0	$917	-	$0.00	$0.07	-	$0	$30	-
65+ years	0	3	-	0	5	-	$0	$131	-	$0.00	$0.01	-	$0	$26	-
Total	**0**	**38**	**-**	**0**	**62**	**-**	**$0**	**$2,070**	**-**	**$0.00**	**$0.17**	**-**	**$0**	**$33**	**-**

Table 3a: COVID-19 Vaccinations (Pharmacy) - This table will only be populated for customers who have coverage under the Aetna Pharmacy Benefit plan. This data is not included in the total in any of the other data tables.

	# of Unique Claimants			# of Vaccinations			Rx Paid Amount			Rx Paid PMPM			Cost per Vaccination		
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	0	0	-	0	0	-	$0	$0	-	$0.00	$0.00	-	$0	$0	-
3 - 12 years	0	2	-	0	3	-	$0	$120	-	$0.00	$0.01	-	$0	$40	-
13 - 19 years	0	9	-	0	15	-	$0	$600	-	$0.00	$0.05	-	$0	$40	-
20 - 24 years	0	17	-	0	32	-	$0	$1,199	-	$0.00	$0.10	-	$0	$37	-
25 - 49 years	0	136	-	0	235	-	$0	$8,615	-	$0.00	$0.69	-	$0	$37	-
50 - 64 years	0	82	-	0	130	-	$0	$4,842	-	$0.00	$0.39	-	$0	$37	-
65+ years	0	9	-	0	12	-	$0	$480	-	$0.00	$0.04	-	$0	$40	-
Total	**0**	**255**	**-**	**0**	**427**	**-**	**$0**	**$15,857**	**-**	**$0.00**	**$1.27**	**-**	**$0**	**$37**	**-**

Table 4: Emergency Room Cost and Utilization of COVID-19:

	# of Unique Claimants			Medical Paid			Medical Paid PMPM			Visits			Visits per 1,000			Cost per Visit		
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	0	2	-	$0	$494	-	$0.00	$0.04	-	0	2	-	0.0	1.9	-	$0	$247	-
3 - 12 years	0	3	-	$0	$364	-	$0.00	$0.03	-	0	3	-	0.0	2.9	-	$0	$121	-
13 - 19 years	1	2	100.0%	$83	$209	153.1%	$0.01	$0.02	149.3%	1	2	100.0%	1.0	1.9	96.9%	$83	$104	26.6%
20 - 24 years	3	1	-66.7%	$745	$87	-88.4%	$0.06	$0.01	-88.6%	3	1	-66.7%	2.9	1.0	-67.2%	$248	$87	-65.2%
25 - 49 years	14	26	85.7%	$16,481	$62,851	281.4%	$1.34	$5.04	275.5%	14	29	107.1%	13.7	27.9	104.0%	$1,177	$2,167	84.1%
50 - 64 years	7	13	85.7%	$2,581	$4,137	60.3%	$0.21	$0.33	57.8%	8	15	87.5%	7.8	14.4	84.6%	$323	$276	-14.5%
65+ years	1	6	500.0%	$82	$6,340	7,640.6%	$0.01	$0.51	7,522.2%	1	7	600.0%	1.0	6.7	589.3%	$82	$906	1,005.8%
Total	**26**	**53**	**103.8%**	**$19,972**	**$74,481**	**272.9%**	**$1.63**	**$5.97**	**267.2%**	**27**	**59**	**118.5%**	**26.4**	**56.7**	**115.2%**	**$740**	**$1,262**	**70.7%**

Table 5: Teladoc/Telemedicine Cost and Utilization of COVID-19:

	# of Unique Claimants			Medical Paid			Medical Paid PMPM			Visits			Visits per 1,000			Cost per Visit		
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	1	0	-100.0%	$82	$0	-100.0%	$0.01	$0.00	-100.0%	1	0	-100.0%	1.0	0.0	-100.0%	$82.45	$0.00	-100.0%
3 - 12 years	1	0	-100.0%	$82	$0	-100.0%	$0.01	$0.00	-100.0%	1	0	-100.0%	1.0	0.0	-100.0%	$82.45	$0.00	-100.0%
13 - 19 years	0	0	-	$0	$0	-	$0.00	$0.00	-	0	0	-	0.0	0.0	-	$0.00	$0.00	-
20 - 24 years	0	1	-	$0	$54	-	$0.00	$0.00	-	0	2	-	0.0	1.9	-	$0.00	$27.00	-
25 - 49 years	7	20	185.7%	$505	$1,556	208.4%	$0.04	$0.12	203.6%	8	29	262.5%	7.8	27.9	257.0%	$63.06	$53.64	-14.9%
50 - 64 years	11	5	-54.5%	$1,036	$327	-68.4%	$0.08	$0.03	-68.9%	14	5	-64.3%	13.7	4.8	-64.8%	$73.99	$65.40	-11.6%
65+ years	0	2	-	$0	$184	-	$0.00	$0.01	-	0	3	-	0.0	2.9	-	$0.00	$61.28	-
Total	**20**	**28**	**40.0%**	**$1,705**	**$2,120**	**24.3%**	**$0.14**	**$0.17**	**22.4%**	**24**	**39**	**62.5%**	**23.4**	**37.5**	**60.0%**	**$71.05**	**$54.37**	**-23.5%**

Table 5a: All Telemedicine (regardless of diagnosis)

	# of Unique Claimants			Medical Paid			Medical Paid PMPM			Visits			Visits per 1,000			Cost per Visit		
Telemedicine	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
All Telemedicine	**372**	**313**	**-15.9%**	**$66,348**	**$52,604**	**-20.7%**	**$5.40**	**$4.21**	**-21.9%**	**995**	**839**	**-15.7%**	**971.5**	**806.7**	**-17.0%**	**$67**	**$63**	**-6.0%**

Table 6: Urgent Care / Retail and Minute Clinic Cost and Utilization of COVID-19:

	# of Unique Claimants			Medical Paid			Medical Paid PMPM			Visits			Visits per 1,000			Cost per Visit		
Age Band	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**
<3 years	1	1	0.0%	$53	$255	385.7%	$0.00	$0.02	378.3%	1	2	100.0%	1.0	1.9	96.9%	$52.50	$127.50	142.9%
3 - 12 years	0	3	-	$0	$180	-	$0.00	$0.01	-	0	3	-	0.0	2.9	-	$0.00	$60.00	-
13 - 19 years	1	3	200.0%	$168	$510	203.6%	$0.01	$0.04	198.9%	2	4	100.0%	2.0	3.8	96.9%	$84.00	$127.50	51.8%
20 - 24 years	8	17	112.5%	$1,367	$1,659	21.4%	$0.11	$0.13	19.5%	12	26	116.7%	11.7	25.0	113.4%	$113.88	$63.80	-44.0%
25 - 49 years	43	113	162.8%	$3,202	$13,840	332.3%	$0.26	$1.11	325.7%	47	153	225.5%	45.9	147.1	220.6%	$68.12	$90.46	32.8%
50 - 64 years	30	47	56.7%	$2,217	$5,020	126.4%	$0.18	$0.40	122.9%	33	59	78.8%	32.2	56.7	76.1%	$67.19	$85.09	26.6%
65+ years	3	6	100.0%	$406	$760	87.3%	$0.03	$0.06	84.4%	4	9	125.0%	3.9	8.7	121.6%	$101.49	$84.49	-16.8%
Total	**86**	**190**	**120.9%**	**$7,412**	**$22,225**	**199.8%**	**$0.60**	**$1.78**	**195.3%**	**99**	**256**	**158.6%**	**96.7**	**246.1**	**154.6%**	**$74.87**	**$86.81**	**16.0%**

Table 7: Inpatient Cost and Utilization of COVID-19:

	# of Unique Claimants			Medical Paid			Medical Paid PMPM			# of Admissions			Admissions per 1,000			Cost per Admission			Average Length of Stay		
Age Band	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**
<3 years	0	0	-	$0	$0	-	$0.00	$0.00	-	0	0	-	0.0	0.0	-	$0	$0	-	0.0	0.0	-
3 - 12 years	0	0	-	$0	$0	-	$0.00	$0.00	-	0	0	-	0.0	0.0	-	$0	$0	-	0.0	0.0	-
13 - 19 years	0	0	-	$0	$0	-	$0.00	$0.00	-	0	0	-	0.0	0.0	-	$0	$0	-	0.0	0.0	-
20 - 24 years	0	0	-	$0	$0	-	$0.00	$0.00	-	0	0	-	0.0	0.0	-	$0	$0	-	0.0	0.0	-
25 - 49 years	0	3	-	$0	$99,470	-	$0.00	$7.97	-	0	3	-	0.0	2.9	-	$0	$33,157	-	0.0	7.7	-
50 - 64 years	4	0	-100.0%	$109,117	$0	-100.0%	$8.88	$0.00	-100.0%	4	0	-100.0%	3.9	0.0	-100.0%	$27,279	$0	-100.0%	3.8	0.0	-100.0%
65+ years	0	0	-	$0	$0	-	$0.00	$0.00	-	0	0	-	0.0	0.0	-	$0	$0	-	0.0	0.0	-
Total	**4**	**3**	**-25.0%**	**$109,117**	**$99,470**	**-8.8%**	**$8.88**	**$7.97**	**-10.2%**	**4**	**3**	**-25.0%**	**3.9**	**2.9**	**-26.1%**	**$27,279**	**$33,157**	**21.5%**	**3.8**	**7.7**	**104.4%**

Table 8: Cost and Utilization of COVID-19 by Medical Cost Category

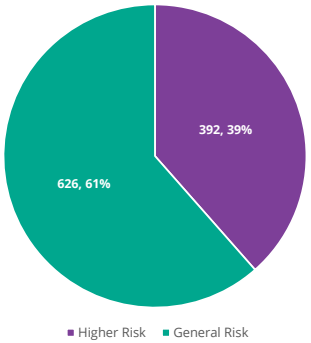
	# of Unique Claimants			Medical Paid			Medical Paid PMPM			Visits			Visits per 1,000			Cost per Visit		
Med Cost Category	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**
Inpatient	4	3	-25.0%	$109,117	$99,470	-8.8%	$8.88	$7.97	-10.2%	4	3	-25.0%	3.9	2.9	-26.1%	$27,279	$33,157	21.5%
Ambulatory	6	2	-66.7%	$264	$0	-100.0%	$0.02	$0.00	-100.0%	6	2	-66.7%	5.9	1.9	-67.2%	$44	$0	-100.0%
Emergency Room	26	53	103.8%	$19,972	$74,481	272.9%	$1.63	$5.97	267.2%	27	59	118.5%	26.4	56.7	115.2%	$740	$1,262	70.7%
Specialist	96	193	101.0%	$20,293	$44,005	116.9%	$1.65	$3.53	113.5%	147	270	83.7%	143.5	259.6	80.9%	$138	$163	18.1%
PCP	47	52	10.6%	$4,524	$7,472	65.2%	$0.37	$0.60	62.6%	62	101	62.9%	60.5	97.1	60.4%	$73	$74	1.4%
Radiology	0	4	-	$0	$174	-	$0.00	$0.01	-	0	4	-	0.0	3.8	-	$0	$44	-
Lab	178	281	57.9%	$20,032	$38,105	90.2%	$1.63	$3.05	87.3%	271	521	92.3%	264.6	500.9	89.3%	$74	$73	-1.1%
Home Health	1	2	100.0%	$195	$197	0.9%	$0.02	$0.02	-0.7%	1	2	100.0%	1.0	1.9	96.9%	$195	$99	-49.6%
Behavioral Health	0	0	-	$0	$0	-	$0.00	$0.00	-	0	0	-	0.0	0.0	-	$0	$0	-
Medical Rx	0	40	-	$0	$2,070	-	$0.00	$0.17	-	0	64	-	0.0	61.5	-	$0	$32	-
Total	**241**	**405**	**68.0%**	**$174,397**	**$265,975**	**52.5%**	**$14.19**	**$21.31**	**50.2%**	**507**	**983**	**93.9%**	**495.0**	**945.1**	**90.9%**	**$344**	**$271**	**-21.3%**

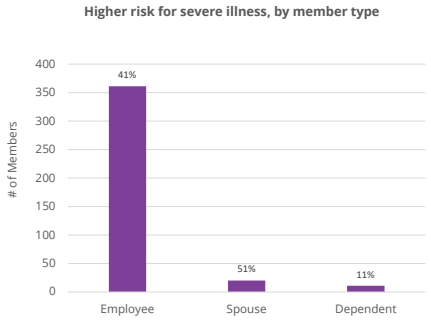
Table 9: Total COVID-19 Medical Cost by Member Type:

	# of Unique Claimants			Medical Paid			Medical Paid PMPM			Distribution of Spend	
Member Type	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**	**Change**	**Prior**	**Current**
Employee	219	366	67.1%	$145,700	$243,992	67.5%	$11.86	$19.55	64.9%	84%	92%
Spouse	6	14	133.3%	$26,022	$14,766	-43.3%	$2.12	$1.18	-44.1%	15%	6%
Child	16	25	56.3%	$2,674	$7,217	169.9%	$0.22	$0.58	165.7%	2%	3%
Total	**241**	**405**	**68.0%**	**$174,397**	**$265,975**	**52.5%**	**$14.19**	**$21.31**	**50.2%**	**100.0%**	**100.0%**

Risk of the Population

392
members are at higher risk for severe illness, representing **38.5%**
of the population, using CDC-identified higher risk factors like age and pre-existing chronic conditions



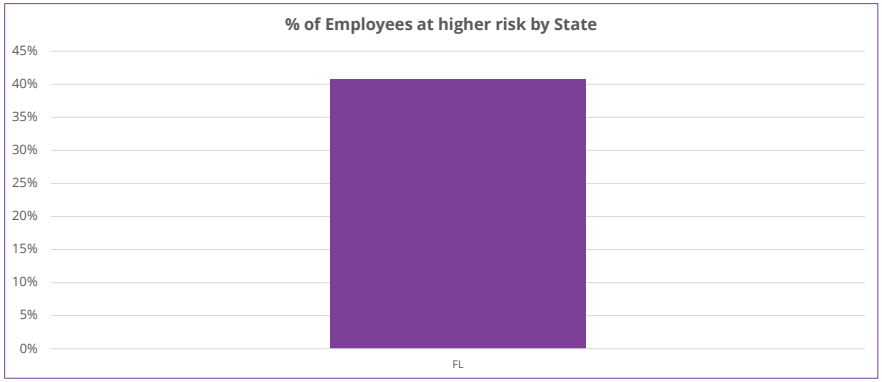


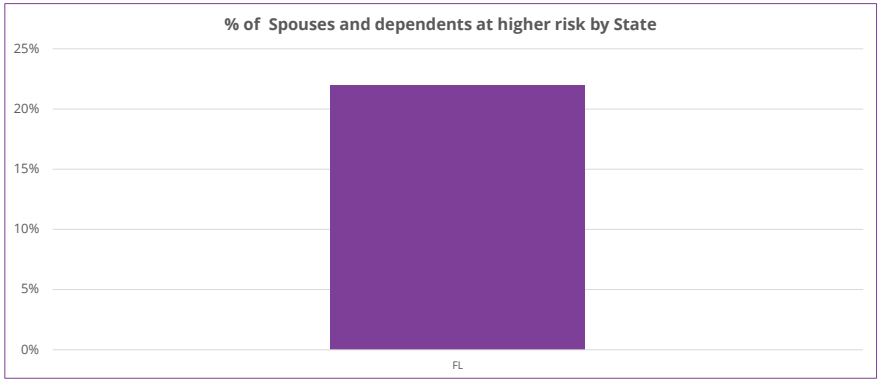
General risk for contracting COVID-19 exists across the population. Age and underlying health conditions are associated with higher risk for severe illness with the potential for severe symptoms, hospitalizations, ICU services, and poorer outcomes. The CDC provides guidelines, recommendations, and resources for those who are considered at higher-risk for severe illness.

The pie chart shows the percent of members with CDC-identified "higher risk for severe illness" factors.

The bar chart to the left shows risk by member type.

The bar charts below provide a sense of risk by state.





Data in these charts is only shown for states where there are at least 50 employees

Alerts for the top 50 counties with high new cases rates in which you have membership

State, County	County population	Your members	Average daily new cases per 100K	Risk Level
Florida, Miami-Dade	2,716,940	1	580.7	High Risk
Florida, Palm Beach	1,496,770	12	278.2	High Risk
Florida, Hendry	42,022	831	232.9	High Risk
Florida, Hillsborough	1,471,968	1	214.6	High Risk
Florida, Okeechobee	42,168	1	201.9	High Risk
Florida, Alachua	269,043	2	200.6	High Risk
Florida, Lee	770,577	97	196.7	High Risk
North Dakota, Cass	181,923	2	194.6	High Risk
Florida, Collier	384,902	5	180.5	High Risk
Georgia, Gwinnett	936,250	1	138.6	High Risk
Florida, Highlands	106,221	2	127.9	High Risk
Florida, Charlotte	188,910	11	121.0	High Risk
Indiana, Delaware	114,135	1	110.8	High Risk
Florida, Sumter	132,420	2	88.8	High Risk
North Carolina, Rutherford	67,029	1	84.8	High Risk
Florida, Glades	13,811	47	77.6	High Risk
Tennessee, Dickson	53,948	1	75.2	High Risk

County Alerts

This table shows the rate of average daily new cases per 100,000 individuals that live in that county. These rates are reflective of the overall general population of the county, not of your specific membership in that county. We are providing this information to inform you which counties you have membership in that are experiencing a high incidence rate of new cases.

The CDC collects new case counts at the county level. We use this information to calculate a '7 day average new case count.' This data is then normalized for population size (new cases per 100,000 individuals) to smooth unusual daily highs or lows, often caused by data collection fluctuations.

The county information is for your top 50 counties in which you have membership that have the highest average daily new cases over the past seven days. Average daily new cases of 25 per 100k members are denoted as high risk (red) and those with 10-24.9 are denoted as emerging risk (orange).

Note: There may be less than 50 counties or none at all depending upon where you have membership vs .the counties with the highest risk.

Vaccinations by State*
All Eligible Members

https://covid.cdc.gov/covid-data-tracker/#vaccinations

1,256

Eligible Members

State	Your Members >= Age 5	Fully Vaccinated Members >= Age 5		Two Dose Regimen # of Members 1st Dose	Two Dose Regimen # Members 2nd Dose	Single Dose Regimen # Members	Booster # Members
AK	-	-	-	-	-	-	-
AL	-	-	-	-	-	-	-
AR	-	-	-	-	-	-	-
AZ	-	-	-	-	-	-	-
CA	-	-	-	-	-	-	-
CO	-	-	-	-	-	-	-
CT	-	-	-	-	-	-	-
DC	-	-	-	-	-	-	-
DE	-	-	-	-	-	-	-
FL	1,246	177	14%	259	161	17	37
GA	-	-	-	-	-	-	-
GU	-	-	-	-	-	-	-
HI	-	-	-	-	-	-	-
ID	-	-	-	-	-	-	-
IL	-	-	-	-	-	-	-
IN	-	-	-	-	-	-	-
IA	-	-	-	-	-	-	-
KS	-	-	-	-	-	-	-
KY	-	-	-	-	-	-	-
LA	-	-	-	-	-	-	-
MA	-	-	-	-	-	-	-
MD	-	-	-	-	-	-	-
ME	-	-	-	-	-	-	-
MI	-	-	-	-	-	-	-
MN	-	-	-	-	-	-	-
MO	-	-	-	-	-	-	-
MS	-	-	-	-	-	-	-
MT	-	-	-	-	-	-	-
NC	-	-	-	-	-	-	-
ND	-	-	-	-	-	-	-
NE	-	-	-	-	-	-	-
NH	-	-	-	-	-	-	-
NJ	-	-	-	-	-	-	-
NM	-	-	-	-	-	-	-
NV	-	-	-	-	-	-	-
NY	-	-	-	-	-	-	-
OH	-	-	-	-	-	-	-
OK	-	-	-	-	-	-	-
OR	-	-	-	-	-	-	-
PA	-	-	-	-	-	-	-
PR	-	-	-	-	-	-	-
RI	-	-	-	-	-	-	-
SC	-	-	-	-	-	-	-
SD	-	-	-	-	-	-	-
TN	-	-	-	-	-	-	-
TX	-	-	-	-	-	-	-
UT	-	-	-	-	-	-	-
VT	-	-	-	-	-	-	-
VA	-	-	-	-	-	-	-
WA	-	-	-	-	-	-	-
WI	-	-	-	-	-	-	-
WV	-	-	-	-	-	-	-
WY	-	-	-	-	-	-	-

** States with less than 10 members will not populate on this page*

Vaccinations by State*

All Eligible Employees

https://covid.cdc.gov/covid-data-tracker/#vaccinations

1,086

Eligible Members

State	Your Employees >= Age 5	Fully Vaccinated Employees >= Age 5		Two Dose Regimen # of Employees 1st Dose	Two Dose Regimen # Employees 2nd Dose	Single Dose Regimen # Employees	Booster # Employees
AK	-	-	-	-	-	-	-
AL	-	-	-	-	-	-	-
AR	-	-	-	-	-	-	-
AZ	-	-	-	-	-	-	-
CA	-	-	-	-	-	-	-
CO	-	-	-	-	-	-	-
CT	-	-	-	-	-	-	-
DC	-	-	-	-	-	-	-
DE	-	-	-	-	-	-	-
FL	1,076	154	14%	231	141	14	36
GA	-	-	-	-	-	-	-
GU	-	-	-	-	-	-	-
HI	-	-	-	-	-	-	-
ID	-	-	-	-	-	-	-
IL	-	-	-	-	-	-	-
IN	-	-	-	-	-	-	-
IA	-	-	-	-	-	-	-
KS	-	-	-	-	-	-	-
KY	-	-	-	-	-	-	-
LA	-	-	-	-	-	-	-
MA	-	-	-	-	-	-	-
MD	-	-	-	-	-	-	-
ME	-	-	-	-	-	-	-
MI	-	-	-	-	-	-	-
MN	-	-	-	-	-	-	-
MO	-	-	-	-	-	-	-
MS	-	-	-	-	-	-	-
MT	-	-	-	-	-	-	-
NC	-	-	-	-	-	-	-
ND	-	-	-	-	-	-	-
NE	-	-	-	-	-	-	-
NH	-	-	-	-	-	-	-
NJ	-	-	-	-	-	-	-
NM	-	-	-	-	-	-	-
NV	-	-	-	-	-	-	-
NY	-	-	-	-	-	-	-
OH	-	-	-	-	-	-	-
OK	-	-	-	-	-	-	-
OR	-	-	-	-	-	-	-
PA	-	-	-	-	-	-	-
PR	-	-	-	-	-	-	-
RI	-	-	-	-	-	-	-
SC	-	-	-	-	-	-	-
SD	-	-	-	-	-	-	-
TN	-	-	-	-	-	-	-
TX	-	-	-	-	-	-	-
UT	-	-	-	-	-	-	-
VT	-	-	-	-	-	-	-
VA	-	-	-	-	-	-	-
WA	-	-	-	-	-	-	-
WI	-	-	-	-	-	-	-
WV	-	-	-	-	-	-	-
WY	-	-	-	-	-	-	-

** States with less than 10 members will not populate on this page*

Billable Top 100 Drugs by Paid Amount

GROUP: '00109695'
RETAIL/MOD: ALL
Begin Date: 2021-01-01
End Date: 2021-12-31

Formulary ALL
Generic ALL

DRUG	FORM_NONFO	BRANDGEN	COMMON_USE	#MBR	AVGCOPAY	CLAIM_CNT	QTY	AVGDAYS
HUMIRA PEN	Formulary	Brand	AUTO-IMMUNE	5	$32.73	44	121	30
IMBRUVICA	Formulary	Brand	CANCER	1	$0.00	13	364	28
VERZENIO	Formulary	Brand	CANCER	1	$0.00	10	560	28
TRULICITY	Formulary	Brand	DIABETES	12	$37.00	75	198	37
COSENTYX PEN	Formulary	Brand	PSORIASIS	2	$30.00	8	22	28
OZEMPIC	Formulary	Brand	DIABETES	14	$47.29	59	174	45
JARDIANCE	Formulary	Brand	DIABETES	16	$56.07	61	3510	57
TRESIBA FLEX	Formulary	Brand	DIABETES	10	$56.54	52	1344	53
GAMMAGARD	Formulary	Brand	IMMUNOGLOBULIN	1	$36.36	11	4400	28
ENBREL MINI	Formulary	Brand	AUTO-IMMUNE	1	$30.00	9	36	28
ENBREL	Formulary	Brand	AUTO-IMMUNE	1	$30.00	9	36	28
OTEZLA	Formulary	Brand	AUTO-IMMUNE	2	$30.00	11	660	30
ROSUVASTATIN	Formulary	Generic	HIGH CHOLESTEROL	49	$23.69	191	13692	72
BIKTARVY	Formulary	Brand	HIV	1	$30.00	12	360	30
NORDITROPIN	Formulary	Brand	GROWTH HORMONE DEFICIENCY	1	$30.00	10	45	24
JANUVIA	Formulary	Brand	DIABETES	10	$47.84	37	2220	60
TREMFYA	Formulary	Brand	PSORIASIS	1	$11.68	3	3	46
ATORVASTATIN	Formulary	Generic	HIGH CHOLESTEROL	76	$4.06	265	18773	71
ZEJULA	Formulary	Brand	CANCER	1	$0.00	2	120	30
VYVANSE	Formulary	Brand	ADHD	16	$31.76	91	2970	31
ELIQUIS	Formulary	Brand	ANTICOAGULANT	10	$57.85	42	3900	46
AIMOVIG	Formulary	Brand	MIGRAINE HEADACHE	5	$36.67	36	44	36
EPIDIOLEX	Formulary	Brand	SEIZURE DISORDERS	1	$50.00	9	1770	30
NOVOLOG	Formulary	Brand	DIABETES	8	$32.90	29	715	41
OCTAGAM	Formulary	Brand	IMMUNOGLOBULIN	1	$50.00	1	1200	28
FARXIGA	Formulary	Brand	DIABETES	7	$39.68	31	1230	39
XARELTO	Formulary	Brand	ANTICOAGULANT	7	$80.63	16	1544	79
LINZESS	Formulary	Brand	IRRITABLE BOWEL SYNDROME	6	$43.00	30	1200	40
ADDERALL XR	NonFormulary	Brand	ADHD	15	$10.26	83	2455	29
HUMULIN R	Formulary	Brand	DIABETES	1	$38.57	7	168	31
TRELEGY	Formulary	Brand	ASTHMA	3	$28.75	24	1560	32
DESCOVY	Formulary	Brand	HIV	1	$40.00	8	210	26
ENTRESTO	Formulary	Brand	CARDIOVASCULAR	2	$67.50	8	1440	90
ADVAIR DISKU	Formulary	Brand	ASTHMA	7	$11.67	24	1920	40

DRUG	FORM_NONFO	BRANDGEN	COMMON_USE	#MBR	AVGCOPAY	CLAIM_CNT	QTY	AVGDAYS
VASCEPA	Formulary	Brand	HIGH CHOLESTEROL	6	$37.00	20	4560	57
VIMPAT	Formulary	Brand	SEIZURE DISORDERS	1	$30.00	13	720	27
LO LOESTRIN	Formulary	Brand	CONTRACEPTION	14	$0.00	31	2044	65
GLYXAMBI	Formulary	Brand	DIABETES	2	$90.00	7	630	90
REXULTI	NonFormulary	Brand	PSYCHIATRIC DISORDERS	1	$50.00	9	270	30
SYMBICORT	Formulary	Brand	ASTHMA	8	$61.32	28	347	38
BREO ELLIPTA	Formulary	Brand	ASTHMA	7	$45.00	20	1800	45
JANUMET	Formulary	Brand	DIABETES	4	$84.00	10	1288	82
SLYND	NonFormulary	Brand	CONTRACEPTION	8	$0.00	26	1344	51
ENSTILAR	Formulary	Brand	SKIN DISORDERS	2	$30.00	6	480	20
SIMVASTATIN	Formulary	Generic	HIGH CHOLESTEROL	25	$0.54	92	6300	68
DUPIXENT	Formulary	Brand	SKIN DISORDERS	1	$30.00	3	12	28
NURTEC	Formulary	Brand	MIGRAINE HEADACHE	4	$40.00	9	84	29
SPIRIVA	Formulary	Brand	RESPIRATORY DISEASE	2	$36.92	15	76	38
SOLIQUA	Formulary	Brand	DIABETES	2	$30.00	11	165	26
PFIZER VACC	NonFormulary	Brand	VACCINE	127	$0.00	232	70	1
ARIPIPRAZOLE	Formulary	Generic	PSYCHIATRIC DISORDERS	4	$16.36	11	630	57
BUPROPN HCL	Formulary	Generic	DEPRESSION	19	$17.64	72	4515	54
VORICONAZOLE	Formulary	Generic	FUNGAL INFECTION	1	$10.00	2	240	30
DULOXETINE	Formulary	Generic	DEPRESSION	16	$15.95	69	3420	49
ANASTROZOLE	Formulary	Generic	CANCER	5	$0.00	16	1365	87
NOVOLOG MIX	Formulary	Brand	DIABETES	2	$70.00	3	190	64
ZENPEP	Formulary	Brand	METABOLIC/ENZYME DISORDERS	1	$60.00	1	500	83
MODERNA VAC	NonFormulary	Brand	VACCINE	120	$0.00	182	81	1
FLUCLVX QUAD	NonFormulary	Brand	VACCINE	133	$0.37	133	126	11
PREGABALIN	Formulary	Generic	SEIZURE DISORDERS	6	$9.13	23	1905	37
ANORO ELLIPT	Formulary	Brand	ASTHMA	2	$38.57	7	840	60
SYNJARDY	Formulary	Brand	DIABETES	2	$30.00	11	660	30
CONCERTA	NonFormulary	Brand	ADHD	3	$10.00	14	420	30
JANUMET XR	Formulary	Brand	DIABETES	1	$90.00	4	720	90
ENBREL SRCLK	Formulary	Brand	AUTO-IMMUNE	1	$30.00	1	4	28
LOSARTAN/HCT	Formulary	Generic	CARDIOVASCULAR	18	$22.21	68	5190	70
LEVETIRACETA	Formulary	Generic	SEIZURE DISORDERS	4	$22.49	16	3870	75
SHINGRIX	NonFormulary	Brand	VACCINE	22	$0.00	32	32	4
OXYCOD/APAP	Formulary	Generic	PAIN	41	$8.37	114	8194	18
VALACYCLOVIR	Formulary	Generic	HERPES	22	$11.05	50	1592	27
EPINEPHRINE	Formulary	Generic	ALLERGY	9	$10.00	9	20	30
RYBELSUS	Formulary	Brand	DIABETES	2	$75.00	2	180	90
TOVIAZ	Formulary	Brand	KIDNEY/BLADDER DISORDERS	1	$16.15	13	390	30
OLM MED/HCTZ	Formulary	Generic	CARDIOVASCULAR	5	$22.94	17	1350	79
SEVELAMER	Formulary	Generic	KIDNEY/BLADDER DISORDERS	2	$18.00	5	2160	54
CLIMARA PRO	Formulary	Brand	FEMALE HORMONE REPLACEMENT	2	$42.86	14	80	41

DRUG	FORM_NONFO	BRANDGEN	COMMON_USE	#MBR	AVGCOPAY	CLAIM_CNT	QTY	AVGDAYS
BASAGLAR	Formulary	Brand	DIABETES	4	$62.69	10	210	50
MYCOPHENOLIC	Formulary	Generic	IMMUNOSUPPRESSANT THERAPY	2	$10.00	13	780	30
BREZTRI AERO	Formulary	Brand	ASTHMA	2	$30.00	7	75	30
LEFLUNOMIDE	Formulary	Generic	AUTO-IMMUNE	3	$9.86	22	660	30
FLUVOXAMINE	Formulary	Generic	DEPRESSION	2	$10.00	9	510	30
EZETIMIBE	Formulary	Generic	HIGH CHOLESTEROL	5	$28.33	12	1020	85
OLANZA/FLUOX	Formulary	Generic	PSYCHIATRIC DISORDERS	1	$100.00	4	360	90
ALBUTEROL	Formulary	Generic	ASTHMA	87	$10.33	180	3890	23
TRINTELLIX	Formulary	Brand	DEPRESSION	1	$30.00	9	270	30
LEVEMIR	Formulary	Brand	DIABETES	3	$22.50	12	119	33
BUPREN/NALOX	Formulary	Generic	PAIN	3	$6.67	18	1320	30
TELMISA/HCTZ	Formulary	Generic	CARDIOVASCULAR	6	$18.57	35	1935	55
RESTASIS	NonFormulary	Brand	EYE DISORDERS	2	$75.00	4	360	45
ETONOGESTREL	Formulary	Generic	CONTRACEPTION	4	$0.00	16	36	63
DOXYCYCL HYC	Formulary	Generic	INFECTION	68	$9.14	75	1558	11
FLOVENT DISK	Formulary	Brand	ASTHMA	3	$40.00	9	780	43
XIGDUO XR	Formulary	Brand	DIABETES	1	$90.00	2	360	90
COMBIGAN	Formulary	Brand	EYE DISORDERS	2	$42.50	12	90	32
PRAVASTATIN	Formulary	Generic	HIGH CHOLESTEROL	14	$24.52	42	3360	80
LETROZOLE	Formulary	Generic	CANCER	3	$0.00	7	390	53
LAMOTRIGINE	Formulary	Generic	SEIZURE DISORDERS	8	$9.70	39	3210	50
RAYOS	NonFormulary	Brand	INFLAMMATION	1	$50.00	1	30	30
ADVAIR HFA	Formulary	Brand	ASTHMA	1	$18.00	5	60	30
PRALUENT	Formulary	Brand	HIGH CHOLESTEROL	1	$30.00	6	12	28

EXHIBIT 3

Benefits Match-Up – a,b,c (In Word format)

A request for any documents in Word or Excel may be made to:

Theresa Conley
Siver Insurance Consultants
tconley@siver.com

EXHIBIT 4

Most Utilized Provider Comparison Match-Up (In Excel format)

A request for any documents in Word or Excel may be made to:

Theresa Conley
Siver Insurance Consultants
tconley@siver.com

EXHIBIT 5

Wellness Information

Congratulations

School Board of Hendry County

We won an Aetna® Workplace Well-being Above and Beyond Award.

This is based on the evaluation of our employer well-being program. And because of what we've accomplished, we're taking home the **silver**. A big thanks to everyone who participated in our well-being program. We couldn't have won this esteemed award without you. Your commitment to well-being has helped create a healthier, happier place to work.

Aetna.com

aetna®

School Board of Hendry County's 2021 Well-being Communication Strategy

The right approach makes all the difference

You already know that a wellness program can help your employees understand their personal health needs and motivate them to make positive changes. But the value of the program depends on engaging your employees at the right times, in the right ways, with the right messaging.

In this strategy, you will find insight and tools to help create a communications plan to get your employees engaged and keep them more involved in their own health.

Getting Started

The more you know about our wellness program and your population, the easier it will be for you to motivate your employees.

Get buy-in from your management team
Management support is important for a successful program launch. People like to follow what their leaders believe in. Encouraging participation from your leadership team is a great way to help engage your employee population.

Decide how the Aetna program fits with your other wellness programs
Will this program serve as your core wellness offering or complement other existing wellness programs and initiatives? Coordinate communication around your wellness program to maximize effort.

Know how your employees will react to using an online wellness program
If your employees have not been exposed to online wellness tools or a health assessment, consider scheduling training sessions to introduce the program. This can help you showcase the program's value and ease potential privacy concerns.

95.35.110.1 (11/20)

Developing your communication strategy

Ongoing communication is critical to the success of any new program. You want a communication plan that works for your organization, based on how you communicate.

Create a communication strategy that works

Stage your communications to create awareness and keep interest going throughout the year. It may take several communications before some employees are intrigued enough to try the program.

Time your launch for maximum effect

Choose a time when your employees will be able to focus on the messages you send them. Consider avoiding your busiest times of the year (such as during tax season for accounting firms). Also, avoid times when employees usually take vacations or celebrate holidays.

Use both electronic and print communications

Multiple communications delivered around the same time will help reinforce the message. When launching the program, you may consider delivering an email or newsletter to announce the program, followed shortly by a postcard.

Communication materials

You can choose from a variety of promotional materials. Use the ones that will work best for your organization.

- **Emails:** Use the preformatted emails to send information to employees. Be creative in the subject line to catch your employee's attention so they can quickly identify the email.
- **Flyer:** Flyers can be printed and/or posted on an intranet site or in break rooms. If you use paper paychecks, flyers may be stapled or added to the envelopes.
- **Text:** Use the information from the flyers to provide text on the health topic. The text would be available for use in a newsletter or to promote the topic via an intranet or internet site.
- **Podcast:** Some of the topics provide a link to a podcast. These are approximately 7-10 minutes long and may be shared with employees.
- **Engagement:** Use the communication materials to solicit testimonials, engage members in raffle drawings, or invite members to post a picture of themselves doing something healthy. Consider creating quizzes to encourage employees to read the materials and provide the answers to enter in prize drawings.

Monthly well-being messages: In addition to these communications items listed in this document, you will receive quarterly Well-being topics with supporting communication. These may provide similar or duplicate information at times, please choose the method or document that best suits your needs.

Setting goals and achieving success

Before you launch your program, decide what your participation goals are. This will help you measure success. You will also be able to track program utilization. Reevaluate your goals each year. As your employees become more familiar with the program, you may want to set the bar higher. Our most strategic customers are ones that provide an incentive and reward program, convey management support for the program and provide a consistent communications strategy throughout the year.

95.35.110.1 (11/20)

Quarter 1

Month 1: January	Communication Tools	Well-being Topic
Promote benefits and registration on our Aetna member website and Aetna Health℠ app. Journey to your Best Health Video	Aetna member website and Aetna Health℠ app flyer Enhanced Wellness flyer COVID support resources	Starting strong, staying well Flyer in English and Spanish Additional Health & Wellness Topics

Month 2: February	Communication Tools	Well-being Topic
Educate members the importance of preventive care. Time for Care	Preventive care flyer in English and Spanish	Exercising for a healthy heart Flyer in English and Spanish

Month 3: March	Communication Tools	Well-being Topic
Teladoc® offers 24/7 access to board-certified doctors via phone, mobile, and video that will diagnose, treat and prescribe medications (if necessary) for common health issues.	Teladoc engagement center Health Guide Options for care flyer	Getting screened for colon cancer Flyer in English and Spanish

Quarter 2

Month 4: April	Communication Tools	Well-being Topic
Online wellness programs that offer a personalized approach to improve members health.	Health Assessment & Online Coaching flyer Simple Steps Incentive flyer in English & Spanish	Keeping workplace stress in check Flyer in English and Spanish Virgin Pulse Get Active Challenge (Great American Adventure)

Month 5: May	Communication Tools	Well-being Topic
Help members discover the value-added programs and services of their health plan.	Discount flyer & Video Mind Check flyer Behavioral Health Site	Nurturing mental and emotional health Flyer in English and Spanish Workplace Well-being Award

Month 6: June	Communication Tools	Well-being Topic
Our Aetna Maternity program provides support to help members have a healthy pregnancy.	Maternity flyer Maternity Journey Video Breast Feeding Support	Managing migraines Flyer in English and Spanish

95.35.110.1 (11/20)

Quarter 3

Month 7: July	Communication Tools	Well-being Topic
A MinuteClinic is a walk-in clinic inside a CVS Pharmacy that provides convenient services for minor illnesses and injuries. They also provide weight management and tobacco cessation coaching at no cost to the member.	Neighborhood well-being flyer HealthHub/Minute Clinic	Maintaining musculoskeletal health Flyer in English and Spanish Virgin Pulse Get Active Challenge (World Tour)

Month 8: August	Communication Tools	Well-being Topic
Preventive care covers many checkups, screenings, vaccines, prenatal care services, contraceptives and more with no out-of-pocket costs.	Preventive brochure Simple Steps Health Assessment	Getting back to better sleep Flyer in English and Spanish Biometric Screenings Flyer

Month 9: September	Communication Tools	Well-being Topic
Disease management is available to members who need additional assistance in managing a new or ongoing diagnosis.	Aetna In Touch Care flyer and Spanish Health Decision Support Tool flyer	Eating healthy for the whole family Flyer in English and Spanish

Quarter 4

Month 10: October	Communication Tools	Well-being Topic
The cancer support centers provide comprehensive support tools on our Aetna member secure website.	Cancer support flyer CVS Flu Shots	Feeling good through gratitude Flyer in English and Spanish

Month 11: November	Communication Tools	Well-being Topic
Our Aetna Maternity program provides personalized nurse support to help members have a healthy pregnancy.	Maternity support flyer Women's Health Tips Tobacco cessation flyer Reduce Risk for Diabetes	Treating and preventing prediabetes Flyer in English and Spanish

Month 12: December	Communication Tools	Well-being Topic
The 24-hour nurse line gives members access to registered nurses who can answer their questions on a variety of health topics.	Informed health line flyer	Staying mindful through the holidays Flyer in English and Spanish

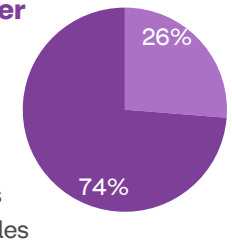
2020 Executive Summary

Report reflects data from January 1, 2020 - December 31, 2020
Prepared by: Kim Sandmaier, Wellness Account Consultant

Demographics

Membership	
Employees	882
Members	1,043
Average Age	41

Gender



Aetna Health

- 578 registered subscribers since enabled
- 4 claim status
- 1 EOB inquiry
- 2 DocFind
- 10 discounts
- 10 simple steps

Enhanced Wellness Programs

Biometric Screenings

Fasting venipuncture screening not completed due to COVID.

Onsite Flu Shots postponed due to COVID.

Simple Steps to a Healthier Life

<30 completed the health assessment so there is no aggregate reporting (13 completed). This was a decrease from previous year.

Get Active

- Platform Registration: 583
- Q1 Steps to be Healthier: 170 participants, Total steps 68,274,197
- Q2 Food around the Globe: 41 participants, total steps 33,460,626
- Q3 World at Play: 150 participants, Total steps 60,195,570
- Q4 No participants (Mindfulness)
- Promote Healthy Habit Challenges

Chronic Care Programs

In Touch Care Activity

- Total Participation = 462
- 1:1 Support=96 (9.2%)
- Digital Support= 366 (35%)
- Overall Participation: 44% (same as 2019)
- Unable to be Reached

Clinical Care Considerations

Level 1 = 7 + Level 2 = 266 + Level 3 = 131

- Condition Drug Monitoring

Aetna Maternity Program

- New pregnancy wedge pillow if enroll before 16th week
- Identified = 31 (3%)
- Total participation = 2 (66%)
  - Nurse engagement = 1
  - Supportive = 0
  - Fulfillment = 1
  - Opt-out = 0

Clinical & Preventive

Top 5 Clinical Conditions

Disease Description	Prevalence	BOB Prevalence
Hypertension	24.5%	12.5%
Hyperlipidemia	21.1%	12.2%
Obesity	15.1%	5.6%
Diabetes Mellitus	8.3%	4.5%
Low Back Pain	9.8%	5.6%

Preventive Care Utilization

Preventive Care - Claims	Prior Year Compliance Rate	Current Year Compliance Rate	BOB Compliance Rate
Well Baby Visits	72.4%	54.2%	63.8%
Childhood Preventive Care Visits	43.1%	46.8%	36.5%
Adult Preventive Care Visits	15.2%	16.3%	15.4%
Well Woman Exam (Annual Gynecological Exam)	25.2%	25.4%	16.4%
Childhood Immunizations	34.5%	37.5%	55.2%
Pap Smear	25.0%	23.7%	15.6%
Mammography	32.8%	29.1%	22.6%
Cholesterol Test	9.2%	7.7%	9.0%
Colorectal Screening	10.0%	8.3%	6.0%

Recommendations

Increase Communications

- Consider a monthly wellness newsletter
- Consider educational campaign with wellness coaches
- Consider communications / educational materials that focus on top chronic conditions

Wellness Challenge Participation

- Promote Get Active program
- Encourage employees to complete their health assessment and their online health coaching journey to earn incentive ($50 Gift Card) after 6/1

Continued Data Analysis

- Start Quest biometric screening implementation in May 2020
- Monitor wellness allowance expense of $100,000

EXHIBIT 6

Medical Census (In Excel format)

A request for any documents in Word or Excel may be made to:

Theresa Conley
Siver Insurance Consultants
tconley@siver.com