School District of Hendry County
Benefits Match-Up
Exhibit 3b – Aetna MC Plan 2

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK	**Write "Match" or Fill In Differences**
Plan Name:	Aetna – MC Plan 2		
MEDICAL			Please note any program limitation or prior authorization programs for each type of benefit when
Lifetime Maximum	Unlimited		
Calendar Year Deductible Individual / Family Maximum	$6,000 per person / $12,000 per family	$8,000 per person / $16,000 per family	
Deductible Info:	Deductibles accumulate separately In and Out of Network. Copays do not accumulate towards the deductible. Family deductible is a cumulative deductible for all family members.		
Out-of-Pocket (OOP) Maximum Individual / Family Maximum	$6.250 per person / $12,500 per family	$10,000 per person / $20,000 per family	
Out-of-Pocket Info:	OOP amounts accumulate separately for In and Out of Network. Copayments, Coinsurance and Deductibles accumulate towards the OOP max. Family out-of-pocket is a cumulative out-of-pocket for all family members.		
Pre-Certification	Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care.		
Coinsurance (Once Deductible is met)	60%	50%	
Physician's Services			
Primary Physician Office Visit	$40 copay	50% after deductible	
Specialist Physician Office Visit	$80 copay	50% after deductible	
Maternity Office Services			
Family Physician	$40 copay	50% after deductible	
Specialist	$80 copay	50% after deductible	
Walk-In Center	$40 copay	50% after deductible	
Physician Svcs at Hospital	60% after plan deductible	50% after deductible	
RAP Provider Svcs at Hospital	60% after plan deductible	50% after deductible	
RAP Provider Svcs at ASC	60% after plan deductible	50% after deductible	

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Plan Name:	Aetna – MC Plan 2		
Physician Svcs at Locations other than Office Hospital and ER			
Family Physician	60% after plan deductible	50% after deductible	
Specialist	60% after plan deductible	50% after deductible	
Preventive Care			
Well Child	Covered 100% - No Deductible	50% deductible waived	
Primary Physician	Covered 100% - No Deductible	50% after deductible	
Specialist Physician Office Visit	Covered 100% - No Deductible	50% after deductible	
Mammograms	Covered 100% - No Deductible	50% after deductible	
Colonoscopies	Covered 100% - No Deductible	50% after deductible	
Medical / Surgical Care at a Facility			
Ambulatory Surgical Center (ASC)	60% after plan deductible	50% after deductible	
Inpatient Hospital Facility (per admit)	60% after plan deductible	50% after deductible	
Outpatient Hospital Facility (per visit) (Surgical)	60% after plan deductible	50% after deductible	
Urgent Care Center Services			
	$100 Copay	50% after deductible	
Emergency Services			
Facility (per visit)	$300 Copay	$300 Copay	
Physician Svcs at ER	60% after plan deductible	60% after INN plan deductible	
Ambulance	60% after plan deductible	60% after In-Network Deductible	

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Plan Name:	Aetna – MC Plan 2		
Diagnostic Testing			
Physician Office Family Specialist	 $40 copay $80 copay	50% after deductible	
Independent Clinical Lab	100%	50% after deductible	
Independent Diagnostic Testing Center	100%	50% after deductible	
Outpatient Hospital Facility	$300 copay	50% after deductible	
Advanced Imaging (AIS) (MRI, MRA, PET, CT& Nuclear Medicine)			
Physician Office Family Specialist	 $40 copay $80 copay	50% after deductible	
Independent Diagnostic Testing Center	100%	50% after deductible	
Outpatient Hospital Facility	$300 copay	50% after deductible	
Outpatient Therapy			
Physician Office Family Specialist	$40 copay $40 copay	50% after deductible	
Outpatient Rehab Facility	$40 copay	50% after deductible	
Outpatient Hospital Facility	$40 copay	50% after deductible	
Note: Calendar Year Maximums:	20 visits – Manipulative Therapy 20 visits – Physical Therapy 20 visits – Occupational Therapy 20 visits – Speech Therapy 10 Visits – Acupuncture		
Mental Health & Substance Abuse Dependency Services			
Physician Office Family Specialist	$80 copay $80 copay	50% after deductible	

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Plan Name:	Aetna – MC Plan 2		
Inpatient Hospital Facility	100% after plan deductible	50% after deductible	
Outpatient Hospital Facility	100%	50% after deductible	
Emergency Room Facility	100%	50% after deductible	
Physician Svcs at Hospital	100% after plan deductible	50% after deductible	
Physician Svcs at ER	100%	50% after deductible	
Physician Svcs at Locations other than Office, Hospital and ER	100%	50% after deductible	
Durable Medical Equipment and Prosthetic Devices			
In-Network Motorized Wheelchairs	60% after deductible	50% after deductible	
All Other	60% after deductible	50% after deductible	
Orthotics & Prosthetics			
Physician Office Family Specialist	60% after deductible	50% after deductible	
Skilled Nursing Facility			
	60% after deductible	50% after deductible	
Note:	Benefits are limited to 60 visits per year.		
Infusion Therapy			
In Home/Physician Office	$80 copay	50% after deductible	
Outpatient Hosp or Facility	Cost share is based on place of service	Cost share is based on place of service	
Home Health Care			
	60% after deductible	50% after deductible	
Note:	Benefits are limited to 60 visits per year.		

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Plan Name:	Aetna – MC Plan 2		
Hospice Care			
	60% after deductible	50% after deductible	
Autism Therapies			
	$80 copay	50% after deductible	
PRESCRIPTIONS			
RETAIL – 31 Day Supply	In-Network	Out-of-Network	
Annual Drug Deductible	No deductible		
Tier 1	$15 copay	20% of submitted cost; after applicable in-network cost share	
Tier 2	$50 copay	20% of submitted cost; after applicable in-network cost share	
Tier 3	$85 copay	20% of submitted cost; after applicable in-network cost share	
Specialty Drugs	Limited to a 30-day supply First fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.		
MAIL ORDER – 90 Day Supply			
Tier 1	$30 copay	N/A	
Tier 2	$100 copay	N/A	
Tier 3	$170 copay	N/A	
RETAIL 90 – 90 Day Supply	In-Network only		
Tier 1	$30 copay	$30 copay	
Tier 2	$150 copay	$150 copay	
Tier 3	$255 copay	$255 copay	

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Program Specifics	• If a member/physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic and brand price. • A limited list of OTC medications are covered when filled with a prescription. • Oral chemotherapy drugs are covered 100% • Responsible Quantity – Yes • Responsible Steps – Yes • Prior Auth – Yes • Mandatory Generic – Yes • 90 Day Supply at Retail – Yes • Seasonal Vaccinations covered at 100%. • Preventive Vaccinations covered 100%. • Affordable Care Act mandated female contraceptives and preventive medications are covered 100% in-network.		