



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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
HSA Contribution	\$500 Individual \$1,000 Family	
Deductible (per calendar year)	\$2,500 per Individual \$5,000 per Family	\$5,000 per Individual \$10,000 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.		
Member coinsurance	You pay 30%	You pay 50%
Applies to all expenses except as noted.		
Out-of-pocket limit (per calendar year)	\$6,600 per Individual \$13,200 per Family	\$13,200 per Individual \$26,400 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.		
Lifetime maximum	Unlimited except where otherwise indicated.	
Payment for out-of-network care**	Does not apply	Professional: Prevailing Charges Facility: Facility Charge Review
Primary care physician selection	Optional	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Refer to your plan documents for a full list of services that need this approval. 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	Not required	None
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your network. Log on to Aetna.com to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.		
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine adult physical exams/ immunizations 1 exam per calendar year	Covered 100%; no deductible	50%; after deductible



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Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 months to 24 months • 3 exams from age 25 months to 36 months • 1 exam every 12 months thereafter until age 22	Covered 100%; no deductible	50%; after deductible
Routine gynecological care exams Recommended: 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible	50%; after deductible
Routine mammogram Recommended: One per calendar year. One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%; no deductible	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. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%; no deductible	50%; after deductible
Pre-natal maternity	Covered 100%; no deductible	50%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	Not Covered
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible	Not Covered
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible	50%; after deductible
Routine eye exams 1 routine exam per 24 months.	Covered 100%; no deductible	50%; after deductible
Routine hearing screening	Covered 100%; no deductible	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.	30% coinsurance; after deductible	50%; after deductible
Telehealth consultation with non-specialist	100% after deductible	50%; after deductible
Specialist office visits	30% coinsurance; after deductible	50%; after deductible
Telehealth consultation with specialist	100% after deductible	50%; after deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics	30% coinsurance; after deductible	50%; after deductible
	Designated Walk-in clinics Covered 100%; no deductible	
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.		



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Telehealth consultations for non-emergency services through a walk-in clinic	Your cost sharing amount depends on the type of service and where you receive it. Designated Walk-in clinics Covered 100%; no deductible	50%; after deductible
We pay telehealth screenings and counseling services from a walk-in-clinic as a preventive care benefit.		
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	50%; after deductible
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.	50%; after deductible.
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	30% coinsurance; after deductible	50%; after deductible
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	30% coinsurance; after deductible	50%; after deductible
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	30% coinsurance; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	30% coinsurance; after deductible	50%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room	30% coinsurance; after deductible	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	30% coinsurance; after deductible	Same as in-network care
Non-emergency but Medically Necessary use of ambulance	30% coinsurance; after deductible	50% coinsurance; after deductible
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient coverage When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	30% coinsurance; after deductible	50%; after deductible
Inpatient maternity coverage (includes delivery and postpartum care) When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	30% coinsurance; after deductible	50%; after deductible
Outpatient hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	30% coinsurance; after deductible	50%; after deductible
Outpatient surgery - hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	30% coinsurance; after deductible	50%; after deductible



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Outpatient surgery - freestanding facility	30% coinsurance; after deductible	50%; after deductible
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When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.

MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	30% coinsurance; after deductible	50%; after deductible

When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.

Mental health office visits	30% coinsurance; after deductible	50%; after deductible
Mental health telehealth consultations	100% after deductible	50%; after deductible

When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.

SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	30% coinsurance; after deductible	50%; after deductible

When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.

Residential treatment facility	30% coinsurance; after deductible	50%; after deductible
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When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.

Substance abuse office visits	30% coinsurance; after deductible	50%; after deductible
Substance abuse telehealth consultations	30% coinsurance; after deductible	50%; after deductible

THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy	30% coinsurance; after deductible	50%; after deductible

Includes speech, physical, occupational therapy; limited to 20 visits each therapy per calendar year

Outpatient short-term rehabilitation	30% coinsurance; after deductible	50%; after deductible
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Limited to 20 visits per year
Includes physical, occupational, and speech therapies.

Habilitative physical therapy	30% coinsurance; after deductible	50%; after deductible
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Habilitative occupational therapy	30% coinsurance; after deductible	50%; after deductible
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Habilitative speech therapy	30% coinsurance; after deductible	50%; after deductible
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Autism related physical therapy	30% coinsurance; after deductible	50%; after deductible
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Autism related occupational therapy	30% coinsurance; after deductible	50%; after deductible
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Autism related speech therapy	30% coinsurance; after deductible	50%; after deductible
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Autism related behavioral therapy	30% coinsurance; after deductible	50%; after deductible
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These benefits are combined with outpatient mental health visits

Autism related applied behavior analysis	30% coinsurance; after deductible	50%; after deductible
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Your benefits for these services are the same as any other outpatient mental health other services benefit

OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled nursing facility	30% coinsurance; after deductible	50%; after deductible

Limited to 30 days per year
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.



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Home health care Limited to 40 visits per year Home health care services include private duty nursing. One visit equals a period of four hours or less.	30% coinsurance; after deductible	50%; after deductible
Hospice care - inpatient When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	30% coinsurance; after deductible	50%; after deductible
Hospice care - outpatient When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	30%; after deductible	50%; after deductible
Private duty nursing	Not covered	Not covered
Durable medical equipment	30% coinsurance; after deductible	50%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy - home/office	30% coinsurance; after deductible	50%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	30% coinsurance; after deductible	50%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. 100% No deductible after \$50 copay for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Transplants	30% coinsurance; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	50%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	30% coinsurance; after deductible	50%; after deductible
Acupuncture Limited to 20 visits per year	30% coinsurance; after deductible	50%; after deductible
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Basic Infertility	30% coinsurance; after deductible Your cost sharing amount depends on the type of service and where you receive it. You have coverage for the diagnosis and treatment of the underlying cause of infertility.	50%; after deductible



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Comprehensive Infertility Services (Includes Artificial Insemination and Ovulation Induction. Both Comprehensive and ART services are combined to a maximum of 3 cycles per lifetime.)	Not Covered	Not covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), ovulation induction (OI), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Fertility preservation	Not Covered	Not Covered
Vasectomy	30% coinsurance; after deductible	50%; after deductible
Tubal ligation	Covered 100%; no deductible	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Standard Formulary	
Retail	\$10 copay for formulary generic drugs, \$45 copay for formulary brand-name drugs, and \$75 copay for non-formulary brand-name and non-formulary generic drugs up to a 30 day supply at participating pharmacies; after deductible	50% after deductible plus \$10/45/75 copay
Mail Order	\$20 copay for formulary generic drugs, \$90 copay for formulary brand-name drugs, and \$150 copay for non-formulary brand-name and non-formulary generic drugs; after deductible Up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered
Aetna Standard Specialty Drugs	\$10 copay for formulary generic drugs, \$45 copay for formulary brand name drugs, and \$75 copay for non-formulary brand-name and non-formulary generic drugs up to a 30 day supply from Aetna Specialty Pharmacy Network; after deductible	Not Covered
CVS Maintenance Choice (90 day Supply at Retail)	\$20 copay for formulary generic drugs, \$90 copay for formulary brand-name drugs, and \$150 copay for non-formulary brand-name and non-formulary generic drugs; after deductible	Not Covered

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



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Standard Specialty Drug 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: Contraceptive drugs and devices obtainable from a pharmacy.

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

Standard Pre-certification included

Standard Step Therapy included

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

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

GENERAL PROVISIONS

Dependents who are eligible to be on your plan Spouse, children from birth to age 30. Student status of children does not matter.

**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.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

This amount is based on the out-of-network plan you or your employer picks.

- For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.

- For hospitals and other facilities, the amount is based on the Facility Fee Schedule.



School Board of Broward County
Proposed Effective Date: 01-01-2025
Aetna Choice® POS II -- ASC

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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.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.



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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.

- 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 this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

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

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

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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