



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

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>
<b>Benefit Limitations</b> - 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.	
<b>Deductible</b> (per calendar year)	\$3,000 Individual \$9,000 Family
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.	
<b>Member Coinsurance</b>	50%
Applies to all expenses unless otherwise stated.	
<b>Payment Limit</b> (per calendar year)	\$6,350 Individual \$12,700 Family
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.	
<b>Lifetime Maximum</b> Unlimited except where otherwise indicated.	
<b>Primary Care Physician Selection</b>	Optional
<b>Referral Requirement</b>	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	
<b>Routine Well Child Exams</b>	Covered 100%; 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.	
<b>Routine Gynecological Care Exams</b>	Covered 100%; deductible waived
1 exam and pap smear per year, includes related fees.	
<b>Routine Mammograms</b>	Covered 100%; deductible waived
<b>Women's Health</b>	Covered 100%; deductible waived
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	



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

<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived
Includes Preventative and Diagnostic with no age limits	
<b>Routine Eye Exams</b>	\$30 copay; deductible waived
1 routine exam per 24 months.	
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>
<b>Office Visits to member's selected Primary Care Physician</b>	\$35 copay; deductible waived
<b>Specialist Office Visits</b>	\$50 copay; deductible waived
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	
<b>Hearing Exams</b>	Not Covered
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived
<b>Walk-in Clinics</b>	\$35 copay; deductible waived
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	
<b>Allergy Testing</b>	Your cost sharing is based on the type of service and where it is performed
<b>Allergy Injections</b>	Your cost sharing is based on the type of service and where it is performed
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>
<b>Diagnostic X-ray</b>	Covered 100%; deductible waived
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
<b>Diagnostic Laboratory</b>	Covered 100%; deductible waived
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
<b>Diagnostic Complex Imaging</b>	\$100 copay; deductible waived
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>
<b>Urgent Care Provider</b>	\$100 copay; deductible waived
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	\$250 copay; deductible waived
Copay waived if admitted	
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered
<b>Emergency Use of Ambulance</b>	50%; after deductible
<b>Non-Emergency Use of Ambulance</b>	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>
<b>Inpatient Coverage</b>	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Inpatient Maternity Coverage</b>	50%; after deductible
(includes delivery and postpartum care)	
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	



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

<b>Outpatient Hospital</b>	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
<b>Outpatient Surgery - Hospital</b>	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
<b>Outpatient Surgery - Freestanding Facility</b>	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>
<b>Inpatient</b>	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Mental Health Office Visits</b>	Covered 100%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>Other Mental Health Services</b>	Covered 100%; deductible waived
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>
<b>Inpatient</b>	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Residential Treatment Facility</b>	50%; after deductible
<b>Substance Abuse Office Visits</b>	Covered 100%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>Other Substance Abuse Services</b>	Covered 100%; deductible waived
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>
<b>Skilled Nursing Facility</b>	50%; after deductible
Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Home Health Care</b>	50%; after deductible
Limited to 60 visits per year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
<b>Hospice Care - Inpatient</b>	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Hospice Care - Outpatient</b>	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>Private Duty Nursing</b>	Not Covered
<b>Outpatient Short-Term Rehabilitation</b>	\$35 copay; deductible waived
Physical and occupational therapy limited to 20 visits each per year. Speech therapy limited to 45 visits per year. Includes speech, physical, occupational therapy	
<b>Spinal Manipulation Therapy</b>	\$35 copay; deductible waived
Limited to 20 visits per year	
<b>Habilitative Physical Therapy</b>	\$35 copay; deductible waived
<b>Habilitative Occupational Therapy</b>	\$35 copay; deductible waived
<b>Habilitative Speech Therapy</b>	\$35 copay; deductible waived
<b>Autism Behavioral Therapy</b>	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits	
<b>Autism Applied Behavior Analysis</b>	Refer to MBH Outpatient Mental Health All Other
Covered same as any other Outpatient Mental Health All Other benefit	



Flagler County School District  
 Proposed Effective Date: 09-01-2019  
 Aetna Open Access<sup>®</sup> Aetna Select<sup>SM</sup>  
 Standard Plan

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

<b>Autism Physical Therapy</b>	\$35 copay; deductible waived
<b>Autism Occupational Therapy</b>	\$35 copay; deductible waived
<b>Autism Speech Therapy</b>	\$35 copay; deductible waived
<b>Durable Medical Equipment</b>	50%; after deductible
<b>Diabetic Supplies -- (if not covered under Pharmacy benefit)</b>	Not Covered
<b>Affordable Care Act mandated Women's Contraceptives</b>	Covered 100%; deductible waived
<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived
<b>Infusion Therapy</b> Administered in the home or physician's office	50%; after deductible
<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	50%; after deductible
<b>Transplants</b>	50%; after deductible Preferred coverage is provided at an IOE contracted facility only.
<b>Bariatric Surgery</b>	Not Covered
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>
<b>Infertility Treatment</b>	Applicable cost sharing based on the type of service performed and place of service where rendered Diagnosis and treatment of the underlying medical condition only.
<b>Comprehensive Infertility Services</b>	Not Covered Artificial insemination and ovulation induction
<b>Advanced Reproductive Technology (ART)</b>	Not Covered In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery
<b>Vasectomy</b>	Your cost sharing is based on the type of service and where it is performed
<b>Tubal Ligation</b>	Covered 100%; deductible waived

**GENERAL PROVISIONS**

**Dependents Eligibility** - Spouse, children from birth to age 26 regardless of student status.  
 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 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.



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

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/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 and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

Translation of 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](http://www.aetna.com).

May 2019



**Flagler County School District**  
Proposed Effective Date: 09-01-2019  
Aetna Open Access<sup>®</sup> Aetna Select<sup>SM</sup>  
Standard Plan

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

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.

© 2016 Aetna Inc.