Aetna EPO Plan	2021			2022		
	Tier 1 (Broward Health)	Tier 2 (Aetna)	Tier 3 (Out of Network)	Tier 1 (Broward Health)	Tier 2 (Aetna)	Tier 3 (Out of Network)
Deductible						
Individual	$500		Not Covered	$500	**$750**	Not Covered
Family	$1,500		Not Covered	$1,500	**$2,000**	Not Covered
Maximum Out of Pocket						
Individual	$3,000		Not Covered	$3,000	**$3,500**	Not Covered
Family	$6,000		Not Covered	$6,000	**$7,000**	Not Covered
Physician Services						
Primary Care	$0 Copay	$25 Copay	Not Covered	**$10 Copay**	**$30 Copay**	Not Covered
Specialist	$0 Copay	$35 Copay	Not Covered	**$25 Copay**	**$45 Copay**	Not Covered
Preventive Care	No Charge		Not Covered	No Charge		Not Covered
Diagnostic Services						
Lab	10% After CYD	20% After CYD	Not Covered	10% After CYD	20% After CYD	Not Covered
X-Rays	10% After CYD	20% After CYD	Not Covered	10% After CYD	20% After CYD	Not Covered
Advanced Imaging	10% After CYD	20% After CYD	Not Covered	10% After CYD	20% After CYD	Not Covered
Outpatient Surgery						
Facility	$100 Copay	$350 Copay	Not Covered	$100 Copay	$350 Copay	Not Covered
Physician Services	No Charge		Not Covered	No Charge		Not Covered
Emergency Services						
Emergency Room	$300 Copay			$300 Copay		
Ambulance	10% After CYD			10% After CYD		
Urgent Care	$20 Copay	$40 Copay	Not Covered	$20 Copay	**$45 Copay**	Not Covered
Inpatient Hospital						
Facility	$250 Copay	$750 Copay	Not Covered	$250 Copay	$750 Copay	Not Covered
Physician Services	No Charge		Not Covered	No Charge		Not Covered
Mental Health / Substance Abuse Services						
Outpatient	No Charge	$35 Copay	Not Covered	No Charge	$35 Copay	Not Covered
Inpatient	$250 Copay	$750 Copay	Not Covered	$250 Copay	$750 Copay	Not Covered
Other Services						
Allergy Treatment / Testing	10% After CYD	20% After CYD	Not Covered	10% After CYD	20% After CYD	Not Covered
Spinal Manipulation	No Charge	$35 Copay	Not Covered	**$25 Copay**	**$45 Copay**	Not Covered
Home Health Care	No Charge	$10 Copay	Not Covered	No Charge	$10 Copay	Not Covered
Rehabilitation Services	$5 Copay	$10 Copay	Not Covered	$5 Copay	$10 Copay	Not Covered
Habilitation Services	$5 Copay	$10 Copay	Not Covered	$5 Copay	$10 Copay	Not Covered
Skilled Nursing Care	$100 Copay After CYD	$200 Copay After CYD	Not Covered	$100 Copay After CYD	$200 Copay After CYD	Not Covered
Durable Medical Equipment	10% After CYD	20% After CYD	Not Covered	10% After CYD	20% After CYD	Not Covered
Hospice Services	No Charge	10% After CYD	Not Covered	No Charge	10% After CYD	Not Covered
Pharmacy	**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	$10 Copay	$25 Copay	Not Covered	$10 Copay	$25 Copay	Not Covered
Preferred Brand	$30 Copay	$75 Copay	Not Covered	$30 Copay	$75 Copay	Not Covered
Non-Preferred Brand	$50 Copay	$125 Copay	Not Covered	$50 Copay	$125 Copay	Not Covered
Specialty	BHMC Pharmacy: $10 Copay	Other Specialty Pharmacy: $75 Copay	Not Covered	**BHMC Pharmacy: $20 Copay; PrudentRx: 30% Coinsurance**	**Other Specialty Pharmacy: $75 Copay; PrudentRx: 30% Coinsurance**	Not Covered