MIAMI DADE COLLEGE
Effective Date: 01-01-2023
Aetna HealthFund™ Aetna Health Network Only℠ - Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

FUND FEATURES	
HealthFund Amount	$750 Employee $1,500 Family
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	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 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.
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 Out-of-Pocket Limit (i.e. expenses are applied towards the medical out-of-pocket maximum but not the medical deductible) and are not integrated with the Fund (i.e., not eligible for reimbursement from the Fund).
PLAN FEATURES	**IN-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
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. Once Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible.	
Out-of-Pocket Maximum (per calendar year)	$4,000 Individual $8,000 Family
All applicable covered expenses accumulate separately toward the in-network and out-of-network Out-of-Pocket-Maximum. In-network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. Once Family Out-of-Pocket-Maximum is met, all family members will be considered as having met their Out-of-Pocket-Maximum. There is no Individual Out-of-Pocket-Maximum to satisfy within the Family Out-of-Pocket-Maximum.	

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Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Optional
Referral Requirement	None

Telemedicine Consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com/ to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.

PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 and older.	Covered 100%; deductible waived
Routine Well Child Exams (Age and frequency schedules apply)	Covered 100%; deductible waived
Childhood Immunizations	Covered 100%; deductible waived
Routine Gynecological Care Exams 1 exam per 12 months Includes routine tests and related lab fees.	Covered 100%; deductible waived
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	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
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%; deductible waived
Colorectal Cancer Screening Recommended: For all members age 45 and over. Frequency schedule applies.	Covered 100%; deductible waived
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived
Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	Office Hours: $25 copay; After Office Hours/Home: $30 copay; after deductible
Telemedicine Consultation with Non-Specialist	$25 copay; after deductible
Specialist Office Visits	$60 copay; after deductible
Telemedicine Consultation with Specialist	$60 copay; after deductible

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Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$25 copay; after deductible **Designated Walk-in Clinics** Covered 100%; deductible waived
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.	
Telemedicine Consultations for Non-Emergency Services through a Walk-in Clinic	Your cost sharing is based on the type of service and where it is performed **Designated Walk-in Clinics** Covered 100%; deductible waived
If telemedicine preventive screening and counseling services are provided through a walk-in clinic, these services are paid under the preventive care benefit.	
Allergy Testing	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
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic Laboratory	$60 copay; 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 X-ray	$60 copay; 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 X-ray for Complex Imaging Services	$60 copay; 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**
Urgent Care Provider	$75 copay; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$350 copay; after deductible
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Hospital	$300 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	$60 copay for Physician maternity services; after deductible; $300 copay for Facility Services; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	$200 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	$300 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$60 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	

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Mental Health Telemedicine Consultations	$60 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	$300 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	$300 copay; after deductible
Substance Abuse Office Visits	$60 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Substance Abuse Telemedicine Consultations	$60 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	$300 copay; after deductible
Limited to 60 days per year	
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	Covered 100%; after deductible
Limited to 60 visits per year	
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	$300 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Short-Term Rehabilitation	$60 copay; after deductible
Limited to 60 visits per year	
Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$60 copay; after deductible
Limited to 20 visits per year	
Direct access to participating providers without a referral.	
Habilitative Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Behavioral Therapy	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
Covered same as any other Outpatient Mental Health Other Services benefit	
Autism Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	Covered 100%; after deductible
Prosthetics	Covered 100%; after deductible
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.

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Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	$60 copay; 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
Transplants	$300 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Not Covered
Acupuncture Limited to 10 visits per year	$25 copay; after deductible
FAMILY PLANNING	**IN-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
Comprehensive Infertility Services Artificial insemination and ovulation induction	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
Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy Plan Type	Advanced Control Plan - Aetna
Preferred Generic Drugs	
Retail	$20 copay
Mail Order	$40 copay
Preferred Brand-Name Drugs	
Retail	$60 copay
Mail Order	$120 copay
Non-Preferred Generic and Brand-Name Drugs	
Retail	$85 copay
Mail Order	$170 copay
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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Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
$30 copay maximum per fill per 30-day supply of insulin drugs
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
Advanced Control Formulary Aetna Insured Step Therapy
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.
When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

Your HealthFund HRAs are subject to employer-defined use and forfeiture rules, and are unfunded liabilities of your employer. Fund balances are not vested benefits.

This material is for information only. Health benefits 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.

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.
• Durable medical equipment.

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• 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.
• Orthotics except diabetic orthotics.
• 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 or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• 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.

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

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

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.

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.