Miami Dade College
Effective Date: 01-01-2017
Aetna HealthFund™ Aetna Health Network Only℠ - Florida

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

| FUND FEATURES | |
|---|---|
| **HealthFund Amount** | $750 Employee<br>$1,500 Family |
| Amount contributed to the Fund by the employer<br>Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage. | |
| **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 plan year is rolled over into next years 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. |
| **Fund Payment/Assignment** | Network Providers: Automatic Assignment to provider.<br>Non-Network Providers: Member may assign payment to provider. |
| **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 with the Fund (i.e., eligible for reimbursement from the Fund). |
| **PLAN FEATURES** | **IN-NETWORK** |
| **Deductible**<br>(per calendar year) | $1,250 Individual<br><br>$3,750 Family |
| Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>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.<br>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**<br>(per calendar year) | $2,000 Individual<br><br>$5,000 Family |

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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 |
| **PREVENTIVE CARE** | **IN-NETWORK** |
| **Routine Adult Physical Exams/ Immunizations**<br>1 exam every 12 months for members age 22 and older. | Covered 100%; deductible waived |
| **Routine Well Child Exams/Immunizations**<br>(Age and frequency schedules apply) | Covered 100%; deductible waived |
| **Routine Gynecological Care Exams**<br>1 exam per 12 months<br>Includes routine tests and related lab fees. | Covered 100%; deductible waived |
| **Routine Mammograms**<br>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**<br>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.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | Covered 100%; deductible waived |
| **Routine Digital Rectal Exams / Prostate Specific Antigen Test**<br>Recommended for males age 40 and over. | Covered 100%; deductible waived |
| **Colorectal Cancer Screening**<br>Recommended: For all members age 50 and over.<br>Frequency schedule applies. | Covered 100%; deductible waived |
| **Routine Eye Exams** | Covered 100%; deductible waived<br>1 routine exam per 24 months. |
| **Routine Hearing Screening** | Subject to Routine Physical Exam benefit. |
| **PHYSICIAN SERVICES** | **IN-NETWORK** |
| **Primary Care Physician Visits**<br>Includes services of an internist, general physician, family practitioner or pediatrician. | Office Hours: $25 copay; After Office Hours/Home: $30 copay; after deductible |

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| **Specialist Office Visits** | $60 copay; after deductible |
| **Pre-Natal Maternity** | Covered 100%; deductible waived |
| **Walk-in Clinics** | $25 copay; after deductible |
| 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. | |
| **Allergy Testing** | Member cost sharing is based on the type of service performed and the place of service where it is rendered |
| **Allergy Injections** | Member cost sharing is based on the type of service performed and the place of service where it is rendered |
| **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 |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** |
| **Urgent Care Provider** | $75 copay; after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered |
| **Emergency Room** | $200 copay; after deductible |
| Copay waived if admitted | |
| **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 Coverage** | $300 copay; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's 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 |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | |
| **Outpatient Hospital** | $200 copay; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** |
| **Inpatient Mental Illness** | $300 copay; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | |

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| **Outpatient Mental Illness** | $60 copay; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | |
| **ALCOHOL/DRUG ABUSE SERVICES** | **IN-NETWORK** |
| **Inpatient Detoxification** | $300 copay; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | |
| **Outpatient Detoxification** | $60 copay; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | |
| **Inpatient Rehabilitation** | $300 copay; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | |
| **Residential Treatment Facility** | $300 copay; after deductible |
| **Outpatient Rehabilitation** | $60 copay; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | |
| **OTHER SERVICES** | **IN-NETWORK** |
| **Skilled Nursing Facility** | $300 copay; after deductible<br>Limited to 60 days; per calendar year |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | |
| **Home Health Care** | Covered 100%; after deductible<br>Limited to 60 visits; per calendar year |
| Coverage includes nutritional counseling and services of a medical social worker.<br>Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hours or less. | |
| **Hospice Care - Inpatient** | $300 copay; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | |
| **Hospice Care - Outpatient** | Covered 100%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | |
| **Outpatient Rehabilitation Therapy** | $60 copay; after deductible<br>Limited to 60 visits; per calendar year |
| Includes speech, physical, occupational therapy | |
| **Spinal Manipulation Therapy** | $60 copay; after deductible<br>Limited to 20 visits; per calendar year |

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| Direct access to participating providers without a referral. | |
| **Autism Behavioral Therapy**<br>Covered same as any other Outpatient Mental Health benefit. | Refer to MBH Outpatient Mental Health |
| **Autism Applied Behavior Analysis**<br>Covered same as any other Outpatient Mental Health benefit with no age or visit limitations. | Refer to MBH Outpatient Mental Health |
| **Autism Physical Therapy**<br>Covered up to age 22, unlimited visits | $60 copay; after deductible |
| **Autism Occupational Therapy**<br>Covered up to age 22, unlimited visits | $60 copay; after deductible |
| **Autism Speech Therapy**<br>Covered up to age 22, unlimited visits | $60 copay; after deductible |
| **Durable Medical Equipment** | Covered 100%; after deductible |
| **Diabetic Supplies** | Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies. |
| **Prosthetics** | Covered 100%; after deductible |
| **Contraceptive drugs and devices not obtainable at a pharmacy** | Covered 100%; deductible waived |
| **Generic FDA-approved Women's Contraceptives** | Covered 100%; deductible waived |
| **Transplants** | $300 copay; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. |
| **Bariatric Surgery** | Not Covered |
| **FAMILY PLANNING** | **IN-NETWORK** |
| **Infertility Treatment**<br>Diagnosis and treatment of the underlying medical condition. | Member cost sharing is based on the type of service performed and the place of service where it is rendered |
| **Comprehensive Infertility Services**<br>Comprehensive Infertility includes Artificial Insemination and Ovulation Induction. | Not Covered |
| **Advanced Reproductive Technology (ART)**<br>ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. | Not Covered |
| **Vasectomy** | Member cost sharing is based on the type of service performed and the place of service where it is rendered |
| **Tubal Ligation** | Covered 100%; deductible waived |
| **PRESCRIPTION DRUG BENEFITS** | **IN-NETWORK** |
| **Pharmacy Plan Type** | Aetna Premier Plus Open Formulary |

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| **Generic Drugs** | |
| **Retail** | $20 copay |
| **Mail Order** | $40 copay |
| **Preferred Brand-Name Drugs** | |
| **Retail** | $40 copay |
| **Mail Order** | $80 copay |
| **Non-Preferred Brand-Name Drugs** | |
| **Retail** | $70 copay |
| **Mail Order** | $140 copay |
| **Pharmacy Day Supply and Requirements** | |
| **Retail** | Up to a 30 day supply |
| **Mail Order** | Up to a 31-90 day supply from Aetna Rx Home Delivery®. |
| **Premier Plus Specialty** | Up to a 30 day supply from Aetna Specialty Pharmacy Network. |

**Plan Includes:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Oral fertility drugs included.
Oral chemotherapy drugs covered 100%
Premier Plus Pre-certification for Specialty Drugs
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

**GENERAL PROVISIONS**

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| **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.

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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.
• 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.

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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.

**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.

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| **ERROR REPORT** |
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| This is a report that will outline any benefits that did not transfer from AQC to e.Proposal to print on the plan design or to highlight any benefits that were in AQC, but not in e.Proposal. |
| |
| If you receive any errors please log your error in the PE Product Data Report (PDR) , and manually update the plan design(s) with the value(s) you selected in AQC. |
| |
| **Plan Sponsor:** Miami Dade College |
| **Quote:** 60794 |
| **Option:** 1 |
| **Location:** FL |
| **Product:** HF Open HMO |
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| **BENEFIT AVAILABLE IN AQC, BUT NOT IN E-PROPOSAL** |

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| **Benefit Display Name** | Sentence after title |
| **Error at Position** | **Group Name** = Pharmacy **Group Record Id** = 899 **Section Name** = Sentence after title **Section Record Id** = 1005 **Row Record Id** = 2250 **Column Record Id** = 4500 |
| **Rule Error** | No Replacement Text Fragments found for the PFRI |
| **PFRI Details** | |
| **PFRI ID** = 3995 **Product Type** = 1 **Product Basis** = 0 **Package Type** = 0 **Product Category** = 0 **Product Category Type** = 116 **TPID** = 506 **UC Code** = INTOPT **Nature Code** = ZINN **Benefit Class** = OTHR **Ucv SeqNo** = 100032 **Ucv Description** = Med/AHF are Integrated; Med/Rx COINS LMT are Integrated **Context Id** = 10 **Rule Id** = 36 **Rule Class Name** = UcvSeqTextReplacement **BaseRule Class Name** = No Java Class **Column Rec Id** = 4500 **Proposal Variable Id** = 1 **Error** = true **AQC Error** = false **Required Code** = O | |
| | |