aetna

Miami Dade College
Effective Date: 01-01-2017
Aetna Health Network Option℠ - Florida

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$500 Individual	$1,000 Individual
	$1,000 Family	$2,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Applicable covered expenses accumulate simultaneously toward both the in-network and out-of-network Deductible. 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.		
Out-of-Pocket Maximum (per calendar year)	$2,500 Individual	$5,000 Individual
	$3,000 Family	$10,000 Family
All applicable covered expenses accumulate simultaneously toward both the in-network and out-of-network Out-of-Pocket-Maximum. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance. Penalty amounts do not apply. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
Payment for Non-Preferred Care**	Not Applicable	Professional: Prevailing Charges Facility: Prevailing Charges
Primary Care Physician Selection	Optional	Not Applicable
Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%; deductible waived	Not Covered
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	40%; after deductible

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Routine Gynecological Care Exams 1 exam per 12 months Includes routine tests and related lab fees.	Covered 100%; deductible waived	Not Covered
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	40%; 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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	40%; after deductible
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%; deductible waived	Not Covered
Colorectal Cancer Screening Recommended: For all members age 50 and over. Frequency schedule applies.	Covered 100%; deductible waived	Not Covered
Routine Eye Exams	$10 copay; deductible waived 1 routine exam per 24 months.	Not Covered
Routine Hearing Screening	Subject to Routine Physical Exam benefit.	40%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	Office Hours: $30 copay; After Office Hours/Home: $35 copay; deductible waived	40%; after deductible
Specialist Office Visits	$50 copay; deductible waived	40%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
Walk-in Clinics 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.	$30 copay; deductible waived	40%; after deductible
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered

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

Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered. Covered 100% when an office visit charge is not applicable.	Member cost sharing is based on the type of service performed and the place of service where it is rendered
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Laboratory	Covered 100%; deductible waived	40%; 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	Covered 100%; deductible waived	40%; 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	$100 copay; deductible waived	40%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 copay; deductible waived	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$200 copay; deductible waived	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; deductible waived	Refer to participating provider benefit.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	30%; after deductible	40%; 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)	$50 copay for Physician maternity services; deductible waived; 30% for Facility Services; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital	30% per visit; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Mental Illness	30%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Illness	$50 copay; deductible waived	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

PLAN DESIGN & BENEFITS
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ALCOHOL/DRUG ABUSE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Detoxification	30%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification	$50 copay; deductible waived	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation	30%; after deductible	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	30%; after deductible	40%; after deductible
Outpatient Rehabilitation	$50 copay; deductible waived	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered 100%; after deductible Limited to 60 days; per calendar year	40%; after deductible Limited to 240 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%; deductible waived Limited to 60 visits; per calendar year	40%; after deductible Limited to 60 visits; per calendar year
Coverage includes nutritional counseling and services of a medical social worker. 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	Covered 100%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%; deductible waived	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Rehabilitation Therapy	$50 copay; deductible waived Limited to 60 visits; per calendar year	40%; after deductible Limited to 60 visits; per calendar year
Includes speech, physical, occupational therapy		
Spinal Manipulation Therapy	$50 copay; deductible waived Limited to 20 visits; per calendar year	40%; after deductible

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Direct access to participating providers without a referral.		
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	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	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.		
Autism Physical Therapy	$50 copay; deductible waived	40%; after deductible
Covered up to age 22, unlimited visits.		
Autism Occupational Therapy	$50 copay; deductible waived	40%; after deductible
Covered up to age 22, unlimited visits.		
Autism Speech Therapy	$50 copay; deductible waived	40%; after deductible
Covered up to age 22, unlimited visits.		
Durable Medical Equipment	Covered 100%; deductible waived	Not Covered
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	40%; after deductible
Prosthetics	Covered 100%; deductible waived	40%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	40%; after deductible
Transplants	30%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Not Covered	Not Covered
Comprehensive Infertility includes Artificial Insemination and Ovulation Induction.		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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.		

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Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	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	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Premier Plus Open Formulary	
Generic Drugs		
Retail	$20 copay	Not Covered
Mail Order	$40 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	Not Covered
Mail Order	$80 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$70 copay	Not Covered
Mail Order	$140 copay	Not Applicable
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	
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.

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.

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When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
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 "prevailing" charges. We get this data from an external database.
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, coinsurance 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, coinsurance and deductibles.

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.

This material is for information only. 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.

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.

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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.
• 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.