Dear Retiree:

ICUBA's Annual Enrollment for benefits begins February 27, 2023, and ends March 6, 2023. If you are not making changes to your benefits, no action is required to maintain your current elections.

Please note, there are **important changes** regarding prescription pharmacy benefits for retirees enrolled in medical insurance through ICUBA. Effective April 1, 2023, your pharmacy benefits will be administered directly through BlueCross BlueShield, and you will receive a new medical insurance ID card with updated pharmacy coverage information for use in the new plan year. For more information, including answers to frequently asked questions about the pharmacy benefit changes, visit ICUBA's iHUB at www.icubabenefits.info/rxchanges2023.

ICUBA PREMIUM FOR THE PLAN YEAR BEGINNING APRIL 1, 2023

BLUECROSS BLUESHIELD MEDICAL	COVERAGE TIER	MONTHLY RATES	ANNUAL ENROLLMENT INFORMATION
RETIREE UNDER 65 PREFERRED PPO PLAN	Individual Individual+Spouse Individual+Child(ren) Family	$742.00 $1,581.00 $1,337.00 $2,082.00	If you are not making changes to your current elections or coverage level, no action is required. Your current elections will carry forward at the rates listed in the table to the left. If you would like to change your coverage, please complete the enclosed *COBRA Open Enrollment form and return it to: **Ameriflex** 7 Carnegie Plaza Suite 200 Cherry Hill, NJ 08003 Attn: COBRA Department ***Please note, all retiree elections are processed through the COBRA Department at Ameriflex.*** If you have any questions, please contact Ameriflex by calling (888)-868-3539, emailing service@myameriflex.com, or visiting the Ameriflex resource page online at https://myameriflex.com/resources/. To access your account online, visit https://cobra.myameriflex.com/ and enter your username and password. If this is your first time accessing the portal, click the button labeled "New User Registration." For retirees aged 65 and older, enrollment in Medicare Part B is required. The ICUBA plan pays as if Medicare is the primary payer regardless of your election. If you do not enroll in Medicare Part B you may be subject to premium penalties from CMS for more information visit www.medicare.gov/.
RETIREE UNDER 65 HIGH DEDUCTIBLE PPO PLAN	Individual Individual+Spouse Individual+Child(ren) Family	$736.00 $1,568.00 $1,064.00 $1,781.00	
RETIREE OVER 65 PREFERRED PPO PLAN	Individual Individual+Spouse Individual+Child(ren) Family	$1,038.33 $2,212.55 $1,871.36 $2,914.12	
RETIREE OVER 65 HIGH DEDUCTIBLE PPO PLAN	Individual Individual+Spouse Individual+Child(ren) Family	$1,029.47 $2,194.82 $1,488.82 $2,493.18	
DELTA DENTAL INSURANCE	**COVERAGE TIER**	**MONTHLY RATES**	
DENTAL PPO BASE PLAN	Individual Individual+Spouse Individual+Child(ren) Family	$23.80 $55.32 $55.32 $91.59	
DENTAL PPO BUY UP PLAN	Individual Individual+Spouse Individual+Child(ren) Family	$41.69 $83.04 $83.04 $139.65	
DENTAL HMO HMO PLAN	Individual Individual+Spouse Individual+Child(ren) Family	$11.83 $23.73 $23.73 $36.85	
EYEMED VISION INSURANCE	**COVERAGE TIER**	**MONTHLY RATES**	
VISION PPO BASE PLAN	Individual Individual+Spouse Individual+Child(ren) Family	$4.74 $12.15 $12.15 $12.15	
VISION PPO BUY UP PLAN	Individual Individual+Spouse Individual+Child(ren) Family	$7.38 $18.87 $18.87 $18.87	

For more information about benefits available as a retiree covered under an ICUBA plan, visit the iHub online at https://www.icubabenefits.info/icuba-retirees.

If you have any questions, please contact Ameriflex by calling (888)-868-3539, emailing COBRA@myameriflex.com, or visiting the Ameriflex resource page online at https://myameriflex.com/resources/.

Warm regards,

The ICUBA Benefits Team
www.icubabenefits.info

SCAN THE QR CODE TO VIEW RATES AND PLAN SUMMARIES ONLINE

COBRA Open Enrollment Form

Ameriflex

Company Name: _____ Date: _____

Applicant Name (first, middle, last): _____

Member ID (which may be your SSN): _____

Address: _____

City: _____ State: _____ Zip+4: _____ Tel: _____

Gender: M ☐ F ☐ DOB: _____ Marital Status: Single ☐ Married ☐

HRA Enrolled: ☐ Email: _____

APPLICANT COVERAGE

Coverage: Add ☐ Remove ☐ Decline ☐ Keep Same ☐

Plan Name: Medical _____ Dental _____ Vision _____

SPOUSE COVERAGE

Applicant Name (first, middle, last): _____

Address (if different from applicant): _____

City: _____ State: _____ Zip: _____ SSN: _____ DOB: _____

Coverage: Add ☐ Remove ☐ Decline ☐ Keep Same ☐

Plan Name: Medical _____ Dental _____ Vision _____ Rx _____

DEPENDENT COVERAGE: Son ☐ Daughter ☐

Applicant Name (first, middle, last): _____

Address (if different from applicant): _____

City: _____ State: _____ Zip: _____ SSN: _____ DOB: _____

Coverage: Add ☐ Remove ☐ Decline ☐ Keep Same ☐

Plan Name: Medical _____ Dental _____ Vision _____ Rx _____

DEPENDENT COVERAGE: Son ☐ Daughter ☐

Applicant Name (first, middle, last): _____

Address (if different from applicant): _____

City: _____ State: _____ Zip: _____ SSN: _____ DOB: _____

Coverage: Add ☐ Remove ☐ Decline ☐ Keep Same ☐

Plan Name: Medical _____ Dental _____ Vision _____ Rx _____

I verify that the information given is true and correct.

Applicant Signature **Date**

Please mail, fax, or email: Ameriflex COBRA Department 7 Carnegie Plaza, Suite 200, Cherry Hill, NJ 08003

Fax: 609.257.0136 **Email:** COBRA@myameriflex.com

Summary of PPO *Benefits*

Benefit Period April 1, 2023 -March 31, 2024

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels.

ICUBA Preferred PPO Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee responsibility)	
Deductible Per Benefit Period (PBP) Individual Family	 $2,500 $5,000	 $4,000 $10,750
Coinsurance	20%	40%
Out-of-Pocket Maximums PBP *(includes deductible, coinsurance, and medical copays)* Individual Family	 $4,000 $8,000	 $7,500 $15,000
Lifetime Maximum	No Maximum	
Physician Office Visits *(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)*	$15 copay (not subject to deductible)	40% after deductible
Total Care Physician Office Visit *(Internist, Family Practice, Pediatrician)*	0% (not subject to deductible or copayment)	N/A
Embold Physician Office Visit *(Primary Care, Pediatrician, Cardiology, Obstetrics, Joint care, Spine care, Endocrinology, Gastroenterology, Pulmonology, and Dermatology)*		
Teladoc Telemedicine Visit	0% after $5 copay	N/A
Maternity Office Visit Benefit *(initial OB visit only)*	$15 copay (not subject to deductible)	40% after deductible
Specialist Office Visits	$35 copay (not subject to deductible)	40% after deductible
Independent Clinical Labs ** (free standing facilities and office visits) Outpatient Facility (Hospital setting)***	0% (not subject to deductible) 20% coinsurance	40% after deductible
Preventive Care - Annual Physical and Gynecological exam	0% (not subject to deductible)	Not Covered
Chlamydia and STD tests	0% (not subject to deductible)	Not Covered
PAP tests	0% (not subject to deductible)	Not Covered
Prostate cancer screenings (PSA)	0% (not subject to deductible)	Not Covered
Mammograms and Ultrasounds of the Breast	0% (not subject to deductible)	Not Covered
Urinalysis	0% (not subject to deductible)	Not Covered
Venipuncture/Conveyance Fee	0% (not subject to deductible)	Not Covered
General Health Blood Panel, Glucose Test, Lipid Panel, Cholesterol, and ALT/AST.	0% (not subject to deductible)	Not Covered
Adult and Pediatric Immunizations	0% (not subject to deductible)	Not Covered
Related Wellness Services (e.g., blood stool tests, colonoscopies, sigmoidoscopies, electrocardiograms, echocardiograms, and bone mineral density tests)	0% (not subject to deductible)	Not Covered

** Quest Diagnostic Labs is the In-Network Lab for BlueCross BlueShield of Florida.

***Outpatient Facility Lab – If you go to your doctor's office at/in a hospital facility and have lab work done (ex: Moffitt Center)

ICUBA Preferred PPO Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee responsibility)	
Allergy Injections	0% (not subject to deductible)	40% after deductible
Emergency Room Services	0% after $300 copay (waived if admitted)	
Medically Necessary Emergency Transportation	0% after $250 copay	
Convenient Care Clinic (Retail) Minute Clinic- CVS/Healthcare Clinic - Walgreens	0% after $10 copay	
Urgent Care Center	0% after $30 copay	
Hospital Expenses		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Outpatient Surgery Office Setting (Physician or Specialist)	20% (not subject to deductible)	40% after deductible
Outpatient Facility	20% after deductible	40% after deductible
Related professional services	20% after deductible	40% after deductible
Non-Emergent Surgeries with SurgeryPlus Please call 1-855-200-2119 for this separate benefit	*Deductible and coinsurance are waived when utilizing SurgeryPlus services and network*	*Not Covered*
Infertility Services (Counseling and testing to diagnose only)	20% after deductible	40% after deductible
Outpatient Physical Therapy	$20 copay (not subject to deductible)	40% after deductible
	Limit: 60 visits/ benefit period	
Outpatient Speech Therapy (Restorative services only)	$20 copay (not subject to deductible)	40% after deductible
	Limit: 60 visits/ benefit period	
Outpatient Occupational Therapy	$20 copay (not subject to deductible)	40% after deductible
	Limit: 60 visits/ benefit period	
Spinal Manipulation	$20 copay (not subject to deductible)	40% after deductible
	Limit: 60 visits/ benefit period	
Diagnostic Services (X-Ray and other tests)	20% after deductible	40% after deductible
Outpatient Diagnostic Imaging (MRI, MRA, CAT Scan, PET Scan)	Allowed Charges up to $500 Copay	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible
Prosthetic Appliances	20% after deductible	40% after deductible
Hearing Care Services		
Hearing aid screening/exam	20% (not subject to deductible)	
Hearing aid	20% after in-network deductible	
	Combined limit: $1,500/ benefit period	
Temporomandibular Joint Disorder (Medical necessity required; excludes appliances and orthodontic treatment)	20% after deductible	40% after deductible
Inpatient Rehabilitation	20% after deductible	40% after deductible
	Limit: 60 days/ benefit period	
Skilled Nursing Rehabilitation	20% after deductible	40% after deductible
	Limit: 60 days/ benefit period	
Home Health Care	20% after deductible	40% after deductible
Private Duty Nursing	20% after deductible	40% after deductible
Hospice (Inpatient and Outpatient Care)	0% (not subject to deductible)	40% after deductible
Mental Health, Substance Abuse Benefits are provided by Aetna Behavioral Health - Available 24 hours at 877-398-5816		
Mental Health/Substance Abuse		
Inpatient	20% after deductible	40% after deductible
Outpatient	$15 copay (not subject to deductible)	40% after deductible

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program. Please see your Plan Document for detailed information on plan terms and the appeals process. Effective 4/1/2023

ATTENTION ICUBA MEMBERS

ICUBA April 1, 2023 – March 31, 2024 Prescription Medication Plan

ICUBA Pharmacy Benefit Prescription Plan Summary

30-Day Supply

Nationwide Pharmacy Network

You have access to more than 62,000 chain and independent pharmacies including: Costco, CVS, Publix Super Markets Inc., Walgreens, Target, The Medicine Shoppe, Walmart, Winn-Dixie Stores, Inc.

90-Day Supply

Convenient Mail Service Pharmacy

Home Delivery is an easy way to receive up to a 90-day supply of your maintenance medication delivered by mail to your door. Standard shipping is free. Orders are shipped in confidential, tamper-evident packaging from Home Delivery pharmacies.

90-Day at Retail Program

This program allows you to obtain a 90-day supply of your maintenance medication at more than 45,000 participating community pharmacies.

Out-of-Pocket Maximum

In-network Rx copays will be applied toward an individual maximum out-of-pocket of $2,000 and $4,000 for family. Once you reach your out-of-pocket maximum, your prescriptions will be paid at 100% by the plan and no cost to you ($0 copay).

Diabetic Supplies

The following prescribed diabetic supplies are covered at 100%, $0 copay: meters, lancets, lancing devices, test strips, control solution, insulin needles and syringes.

Rx with Over-the-Counter (OTC) alternatives

The Rx with OTC strategy excludes certain prescription products when therapeutically acceptable over-the-counter (OTC) alternatives are available.

Over-The-Counter and Generic Preventive Medications

With a prescription from your physician, the following OTC and generic preventive medications are covered as part of your pharmacy benefit with $0 copay: Aspirin for adults, prenatal vitamins or folic acid for women planning or capable of pregnancy, iron supplementation, oral fluoride supplementation for children, vaccines, Vitamin D for adults, bowel preparation agents for colorectal cancer screening, and select statins for prevention of cardiovascular disease (CVD).

Tobacco Cessation

Tobacco cessation medications are covered with $0 copay when you participate in coaching or counseling options though local Area Health Education Centers, BCBS telephonic coaching or Resources for Living counseling.

Specialty Medications

Certain medications used for treating complex health conditions (e.g. Hepatitis, HIV/AIDS, Oncology, etc.) must be obtained through Optum Specialty Pharmacy with BlueCross BlueShield.

MyRx Toolkit and MyHealthToolkit

Find answers by visiting the **MyRx Toolkit** and **MyHealth Toolkit** through the single sign-on section at http://ICUBAbenefits.org to find your lowest copay, manage Home Delivery prescriptions, keep track of your health history and more!

Care Connected in your Corner

If you have a question about your pharmacy benefit, call the Care Connected team toll-free at **(855) 2811-2218**, 24 hours a day, 7 days a week.

ICUBAcares Pharmacist Advocate Program

If you have a question about your pharmacy benefit, and would like to speak with a Pharmacist at ICUBAcares, call **(877) 286-3967.**

Copayments	**Prescription-Fill Methods***		
Tier	**Retail: Up to a 30-day supply**	***90-Day at Retail Program* Up to a 90-day supply**	**Mail: Up to a 90-day supply**
Low Cost Generics at the Nova Southeast University (NSU) Pharmacy	$0	$0	N/A
Low Cost Generics at all other network pharmacies	$5	$10	$10
Preventive Generics****	$0	$0	$0
Generics: Tier 1 Medications on the Premium Formulary (PF)**	$10	$20	$20
Preferred Brands: Tier 2) Medications on the Premium Formulary	$40	$80	$80
Non-Preferred Brands: Tier 3 Medications Premium Formulary	$75	$150	$150
Preferred specialty at Optum Specialty Pharmacy	$75***	N/A	N/A
Non-preferred specialty at Optum Specialty Pharmacy	$75***	N/A	N/A

‡ Prior authorization may be required to ensure safe and effective use of select prescription drugs. Your physician may be asked to provide additional information to determine medical necessity.

* Unless medically necessary, members will be required to pay the difference in cost between a brand and generic drug if the brand is requested when a generic equivalent is available.

** The PF is a list of medications preferred by your plan that can help you maximize your pharmacy benefit by minimizing your prescription costs.

*** Specialty medications are limited to a 30 Day Supply. Copay Assistance Cards are acceptable to preferred specialty products

**** Prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act (In some cases You may have to meet an additional requirement such as age, sex, and diagnosis to qualify for the $0 copay)

ICUBA Preferred PPO Plan

Aetna Behavioral Health and Substance Abuse

Aetna Open Choice PPO Network

Plan Year April 1, 2023 through March 31, 2024

Employee Assistance Program (EAP), Mental Health, Substance Abuse Benefits and Applied Behavioral Analysis (ABA) Provided by Aetna Behavioral Health - Available 24/7 - 877-398-5816 Deductibles and Out of Pocket Maximum Amounts are COMBINED with BCBS Medical		
	In Network	**Out of Network**
Employee Assistance Program (EAP) * *Up to 6 short-term professional counseling sessions per episode per year. Talk with a licensed clinician regarding stress, relationship issues, grief, etc.*	**$0**	**No coverage**
Inpatient*	**20% after deductible**	**40% after deductible**
Mental Health Hospital Admission*	**20% after deductible**	**40% after deductible**
Substance Abuse Hospital Admission*	**20% after deductible**	**40% after deductible**
Residential* *Residential Services focus on evaluating and stabilizing the patient. They help the patient learn effective ways to cope with the symptoms and impact of the patient's illness.*	**20% after deductible**	**40% after deductible**
Inpatient Detoxification* *Inpatient detoxification provides 24 hour treatment in a residential or hospital setting for patients who are abusing alcohol or other physically addictive drugs. Patients typically stay in detoxification only as long as their withdrawal symptoms require 24 hour medical and nursing services.*	**20% after deductible**	**40% after deductible**
Outpatient	**$15 copayment (not subject to deductible)**	**40% after deductible**
Professional Counseling Sessions *Talk with a licensed clinician regarding anxiety, attention deficit hyperactivity disorder (ADHD), depression, mood disorders, oppositional defiance disorder (ODD), schizophrenia, trauma, etc.*	**$15 copayment (not subject to deductible)**	**40% after deductible**
Psychiatric Medication Evaluation	**$15 copayment (not subject to deductible)**	**40% after deductible**
Applied Behavioral Analysis Therapy* *Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis*	**$15 copayment (not subject to deductible)**	**40% after deductible**
Partial Hospitalization (PHP)* *These programs are longer and more intensive than an IOP, usually 4-6 hours per day, 5-7 days per week. Services include physician and nursing services, as well as group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services. These programs are often used in lieu of an inpatient stay, or as a transition from an inpatient stay.*	**$15 copayment (not subject to deductible)**	**40% after deductible**
Outpatient Detoxification *Monitor withdrawal from alcohol or another substance of abuse and may administer medications that assist with detoxification and recovery from addiction.*	**$15 copayment (not subject to deductible)**	**40% after deductible**
Intensive Outpatient Sessions (IOP) *These planned and structured programs are usually 2-3 hours/day (or evening), and 3-7 days per week. They may include group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services.*	**$15 copayment (not subject to deductible)**	**40% after deductible**
AbleTo *Meet with a therapist and coach via web-based videoconferencing, or over the telephone for a 8 week program for select conditions including breast and prostate cancer recovery, heart problems, diabetes, depression, digestive health, pain management, respiratory problems, substance abuse, anxiety, postpartum depression, caregiver status (child, elder, Autism, etc.), grief/loss, and military transition.*	**$0**	**No coverage**

**Services require prior-authorization*

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Resources *for* Living®

Summary of PPO *Benefits*

Benefit Period April 1, 2023 -March 31, 2024

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels.

ICUBA High Deductible PPO Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee responsibility)	
Deductible Per Benefit Period (PBP) Individual Family	 $4,000 $8,000	 $8,000 $16,000
Coinsurance	30%	50%
Out-of-Pocket Maximums PBP *(includes deductible, coinsurance, and medical copays)* Individual Family	 $5,350 $10,700	 $10,700 $21,400
Lifetime Maximum	No Maximum	
Physician Office Visits *(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)*	0% after $15 copay (not subject to deductible)	50% after deductible
Total Care Physician Office Visit *(Internal Medicine, Family Practice, Pediatrician)*	$0 copay (not subject to deductible or copayment)	N/A
Embold Physician Office Visit *(Primary Care, Pediatrician, Cardiology, Obstetrics, Joint care, Spine care, Endocrinology, Gastroenterology, Pulmonology, and Dermatology)*		
Teladoc Telemedicine Visit	0% after $5 copay	N/A
Maternity Office Visit Benefit *(initial OB visit only)*	0% after $15 copay (not subject to deductible)	50% after deductible
Specialist Office Visits	0% after $35 copay (not subject to deductible)	50% after deductible
Independent Clinical Labs ** (free standing facilities and office visits) Outpatient Facility (Hospital setting)***	0% (not subject to deductible) 30% coinsurance	50% after deductible
Preventive Care - Annual Physical and Gynecological exam	0% (not subject to deductible)	Not Covered
Chlamydia and STD tests	0% (not subject to deductible)	Not Covered
PAP tests	0% (not subject to deductible)	Not Covered
Prostate cancer screenings (PSA)	0% (not subject to deductible)	Not Covered
Mammograms and Ultrasounds of the Breast	0% (not subject to deductible)	Not Covered
Urinalysis	0% (not subject to deductible)	Not Covered
Venipuncture/Conveyance Fee	0% (not subject to deductible)	Not Covered
General Health Blood Panel, Glucose Test, Lipid Panel, Cholesterol, and ALT/AST.	0% (not subject to deductible)	Not Covered
Adult and Pediatric Immunizations	0% (not subject to deductible)	Not Covered
Related Wellness Services (e.g., blood stool tests, colonoscopies, sigmoidoscopies, electrocardiograms, echocardiograms, and bone mineral density tests)	0% (not subject to deductible)	Not Covered

ICUBA High Deductible PPO Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee responsibility)	
Allergy Injections	0% (not subject to deductible)	50% after deductible
Emergency Room Services	0% after $300 copay (waived if admitted)	
Medically Necessary Emergency Transportation	0% after $250 copay	
Convenient Care Clinic (Retail) Minute Clinic- CVS/Healthcare Clinic - Walgreens	0% after $10 copay	
Urgent Care Center	0% after $30 copay	
Hospital Expenses Inpatient	30% after deductible	50% after deductible
Outpatient	30% after deductible	50% after deductible
Outpatient Surgery Office Setting Physician Specialist	0% after $15 Copay 0% after $35 Copay	50% after deductible
Outpatient Facility	30% after deductible	50% after deductible
Related professional services	30% after deductible	50% after deductible
Non-Emergent Surgeries with SurgeryPlus *Please call 1-855-200-2119 for this separate benefit*	*Deductible and coinsurance are waived when utilizing SurgeryPlus services and network*	*Not Covered*
Infertility Services (Counseling and testing to diagnose only)	30% after deductible	50% after deductible
Outpatient Physical Therapy	0% after $20 copay (not subject to deductible)	50% after deductible
	Limit: 60 visits/ benefit period	
Outpatient Speech Therapy (Restorative services only)	0% after $20 copay (not subject to deductible)	50% after deductible
	Limit: 60 visits/ benefit period	
Outpatient Occupational Therapy	0% after $20 copay (not subject to deductible)	50% after deductible
	Limit: 60 visits/ benefit period	
Spinal Manipulation	0% after $20 copay (not subject to deductible)	50% after deductible
	Limit: 60 visits/ benefit period	
Diagnostic Services (X-Ray and other tests)	30% after deductible	50% after deductible
Outpatient Diagnostic Imaging (MRI, MRA, CAT Scan, PET Scan)	Allowed Charges up to $500 Copay	50% after deductible
Durable Medical Equipment (DME)	$2,000 Deductible of the $4,000 Individual Deductible must be satisfied before 30% coinsurance applies	50% after deductible
Prosthetic Appliances		50% after deductible
Hearing aid screening/exam	30% (not subject to deductible)	
Hearing aid	30% after in-network DME deductible	
	Combined limit: $1,500/ benefit period	
Temporomandibular Joint Disorder (Medical necessity required; excludes appliances and orthodontic treatment)	30% after deductible	50% after deductible
Inpatient Rehabilitation	30% after deductible	50% after deductible
	Limit: 60 days/ benefit period	
Skilled Nursing Rehabilitation	30% after deductible	50% after deductible
	Limit: 60 days/ benefit period	
Home Health Care	30% after deductible	50% after deductible
Private Duty Nursing	30% after deductible	50% after deductible
Hospice (Inpatient and Outpatient Care)	0% (not subject to deductible)	50% after deductible
Mental Health, Substance Abuse Benefits are provided by Aetna Behavioral Health - Available 24 hours at 877-398-5816		
Mental Health/Substance Abuse Inpatient	30% after deductible	50% after deductible
Outpatient	0% after $15 copay	50% after deductible

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***Outpatient Facility Lab – If you go to your doctor's office at/in a hospital facility and have lab work done (ex: Moffitt Center) Effective 04/01/2023

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30-Day Supply
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You have access to more than 62,000 chain and independent pharmacies including: Costco, CVS, Publix Super Markets Inc., Walgreens, Target, The Medicine Shoppe, Walmart, Winn-Dixie Stores, Inc.

90-Day Supply
Convenient Mail Service Pharmacy
Home Delivery is an easy way to receive up to a 90-day supply of your maintenance medication delivered by mail to your door. Standard shipping is free. Orders are shipped in confidential, tamper-evident packaging from Home Delivery pharmacies.

90-Day at Retail Program
This program allows you to obtain a 90-day supply of your maintenance medication at more than 45,000 participating community pharmacies.

Out-of-Pocket Maximum
In-network Rx copays will be applied toward an individual maximum out-of-pocket of $2,000 and $4,000 for family. Once you reach your out-of-pocket maximum, your prescriptions will be paid at 100% by the plan and no cost to you ($0 copay).

Diabetic Supplies
The following prescribed diabetic supplies are covered at 100%, $0 copay: meters, lancets, lancing devices, test strips, control solution, insulin needles and syringes.

Rx with Over-the-Counter (OTC) alternatives
The Rx with OTC strategy excludes certain prescription products when therapeutically acceptable over-the-counter (OTC) alternatives are available.

Over-The-Counter and Generic Preventive Medications
With a prescription from your physician, the following OTC and generic preventive medications are covered as part of your pharmacy benefit with $0 copay: Aspirin for adults, prenatal vitamins or folic acid for women planning or capable of pregnancy, iron supplementation, oral fluoride supplementation for children, vaccines, Vitamin D for adults, bowel preparation agents for colorectal cancer screening, and select statins for prevention of cardiovascular disease (CVD).

Tobacco Cessation
Tobacco cessation medications are covered with $0 copay when you participate in coaching or counseling options though local Area Health Education Centers, BCBS telephonic coaching or Resources for Living counseling.

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Certain medications used for treating complex health conditions (e.g. Hepatitis, HIV/AIDS, Oncology, etc.) must be obtained through Optum Specialty Pharmacy with BlueCross BlueShield.

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Low Cost Generics at the Nova Southeast University (NSU) Pharmacy	$0	$0	N/A
Low Cost Generics at all other network pharmacies	$5	$10	$10
Preventive Generics****	$0	$0	$0
Generics: Tier 1 Medications on the Premium Formulary (PF)**	$10	$20	$20
Preferred Brands: Tier 2) Medications on the Premium Formulary	$40	$80	$80
Non-Preferred Brands: Tier 3 Medications Premium Formulary	$75	$150	$150
Preferred specialty at Optum Specialty Pharmacy	$75***	N/A	N/A
Non-preferred specialty at Optum Specialty Pharmacy	$75***	N/A	N/A

‡ Prior authorization may be required to ensure safe and effective use of select prescription drugs. Your physician may be asked to provide additional information to determine medical necessity.
* Unless medically necessary, members will be required to pay the difference in cost between a brand and generic drug if the brand is requested when a generic equivalent is available.
** The PF is a list of medications preferred by your plan that can help you maximize your pharmacy benefit by minimizing your prescription costs.
*** Specialty medications are limited to a 30 Day Supply. Copay Assistance Cards are acceptable to preferred specialty products
**** Prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act (In some cases You may have to meet an additional requirement such as age, sex, and diagnosis to qualify for the $0 copay)

ICUBA High Deductible PPO Plan

Aetna Behavioral Health and Substance Abuse

Aetna Open Choice PPO Network

Plan Year April 1, 2023 through March 31, 2024

Employee Assistance Program (EAP), Mental Health, Substance Abuse Benefits and Applied Behavioral Analysis (ABA) Provided by Aetna Behavioral Health - Available 24/7 - 877-398-5816 Deductibles and Out of Pocket Maximum Amounts are COMBINED with BCBS Medical		
	In Network	**Out of Network**
Employee Assistance Program (EAP) * *Up to 6 short-term professional counseling sessions per episode per year. Talk with a licensed clinician regarding stress, relationship issues, grief, etc.*	**$0**	**No coverage**
Inpatient*	**30% after deductible**	**50% after deductible**
Mental Health Hospital Admission*	**30% after deductible**	**50% after deductible**
Substance Abuse Hospital Admission*	**30% after deductible**	**50% after deductible**
Residential* *Residential Services focus on evaluating and stabilizing the patient. They help the patient learn effective ways to cope with the symptoms and impact of the patient's illness.*	**30% after deductible**	**50% after deductible**
Inpatient Detoxification* *Inpatient detoxification provides 24 hour treatment in a residential or hospital setting for patients who are abusing alcohol or other physically addictive drugs. Patients typically stay in detoxification only as long as their withdrawal symptoms require 24 hour medical and nursing services.*	**30% after deductible**	**50% after deductible**
Outpatient	**$15 copayment (not subject to deductible)**	**50% after deductible**
Professional Counseling Sessions *Talk with a licensed clinician regarding anxiety, attention deficit hyperactivity disorder (ADHD), depression, mood disorders, oppositional defiance disorder (ODD), schizophrenia, trauma, etc.*	**$15 copayment (not subject to deductible)**	**50% after deductible**
Psychiatric Medication Evaluation	**$15 copayment (not subject to deductible)**	**50% after deductible**
Applied Behavioral Analysis Therapy* *Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis*	**$15 copayment (not subject to deductible)**	**50% after deductible**
Partial Hospitalization (PHP)* *These programs are longer and more intensive than an IOP, usually 4-6 hours per day, 5-7 days per week. Services include physician and nursing services, as well as group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services. These programs are often used in lieu of an inpatient stay, or as a transition from an inpatient stay.*	**$15 copayment (not subject to deductible)**	**50% after deductible**
Outpatient Detoxification *Monitor withdrawal from alcohol or another substance of abuse and may administer medications that assist with detoxification and recovery from addiction.*	**$15 copayment (not subject to deductible)**	**50% after deductible**
Intensive Outpatient Sessions (IOP) *These planned and structured programs are usually 2-3 hours/day (or evening), and 3-7 days per week. They may include group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services.*	**$15 copayment (not subject to deductible)**	**50% after deductible**
AbleTo *Meet with a therapist and coach via web-based videoconferencing, or over the telephone for a 8 week program for select conditions including breast and prostate cancer recovery, heart problems, diabetes, depression, digestive health, pain management, respiratory problems, substance abuse, anxiety, postpartum depression, caregiver status (child, elder, Autism, etc.), grief/loss, and military transition.*	**$0**	**No coverage**

**Services require prior-authorization*

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