aetna

Wayne Township Public Schools
Proposed Effective Date: 07-01-2021
Open Access® Elect Choice® - New Jersey

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

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)	None Individual None Family
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%
Payment Limit (per calendar year) Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.	$2,500 Individual $5,000 Family
Lifetime Maximum Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	Covered 100%
Routine Mammograms	Covered 100%
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%
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%
Colorectal Cancer Screening Recommended: For all members age 45 and over. Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.	Covered 100%
Routine Eye Exams 1 routine exam per year	Covered 100%
Newborn Hearing Testing and Monitoring	$40 copay
Routine Hearing Screening	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$20 office visit copay
Specialist Office Visits	$40 office visit copay
Hearing Exams	Not Covered
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	$20 office visit copay

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.

Allergy Testing	Covered 100%
Allergy Injections	Covered 100%
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services) 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.	Covered 100%
Diagnostic Laboratory 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.	Covered 100%
Diagnostic Outpatient Complex Imaging 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.	Covered 100%
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$40 office visit copay
Non-Urgent Use of Urgent Care Provider	$40 copay
Emergency Room Copay waived if admitted	$100 copay
Non-Emergency Care In an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$250 per day for the first 5 days per confinement, thereafter Covered 100%
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$250 per day for the first 5 days per confinement, thereafter Covered 100%
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$200 copay
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$100 copay
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$250 per day for the first 5 days per confinement, thereafter Covered 100%
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$40 copay
Other Mental Health Services	Covered 100%
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$250 per day for the first 5 days per confinement, thereafter Covered 100%
Residential Treatment Facility	$250 per day for the first 5 days per confinement, thereafter Covered 100%
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$40 copay
Other Substance Abuse Services	Covered 100%
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility Limited to 100 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%
Home Health Care Private Duty Nursing not included.	Covered 100%
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%
Private Duty Nursing - Outpatient Limited to 30 eight hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered 100%
Outpatient Speech Therapy Limited to 30 visits per year.	$20 copay

Outpatient Physical and Occupational Therapy Limited to 60 visits per year combined.	$20 copay
Spinal Manipulation Therapy Limited to 25 visits per year	$20 copay
Acupuncture	$40 copay
Habilitative Physical Therapy	Covered 100%
Habilitative Occupational Therapy	Covered 100%
Habilitative Speech Therapy	Covered 100%
Autism Behavioral Therapy	$40 copay
Autism Applied Behavior Analysis	Covered 100%
Autism Physical Therapy	Covered 100%
Autism Occupational Therapy	Covered 100%
Autism Speech Therapy	Covered 100%
Durable Medical Equipment	50%
Prosthetics	$20 copay
Orthotics	$20 copay
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Hearing Aids 1 hearing aid per ear to $1,000 maximum per ear every 24 months for child to age 16.	$20 copay
Infusion Therapy Administered in the home or physician's office	$40 copay
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
Vision Eyewear $125 Combined maximum for all covered eyeglass lenses, frames and contact lenses	No Charge
Transplants	$250 per day for the first 5 days per confinement, thereafter Covered 100%
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$250 per day for the first 5 days per confinement, thereafter Covered 100%
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
Advanced Reproductive Technology (ART) ART coverage includes In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 egg retrievals per lifetime. Coverage includes cryopreservation for iatrogenic infertility only.	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Coverage includes Artificial Insemination and Ovulation Induction.	Your cost sharing is based on the type of service and where it is performed
Vasectomy	Covered 100%
Tubal Ligation	Covered 100%
PHARMACY	**IN-NETWORK**
Pharmacy Plan Type	Aetna Standard Plan opt out with ACSF
Generic Drugs	
Retail	20%
Mail Order	20%
Preferred Brand-Name Drugs	
Retail	20%
Mail Order	20%
Non-Preferred Brand-Name Drugs	
Retail	20%
Mail Order	20%
Retail Out-of-Network Coverage	Not Covered
Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay. Percentage copays will not be doubled
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy

Specialty	Up to a 30 day supply Standard Opt Out Aetna Insured List

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Contraceptives covered up to a 6 supply. Contraceptive copay strategy applies.
A limited list of over-the-counter medications are covered when filled with a prescription.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 12 tablets a month for males for erectile dysfunction.
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
Oral chemotherapy drugs covered 100%
Precertification for specialty drugs included
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.

Prescription Drug Out of Pocket Maximum	$2,500 Individual $5,000 Family

GENERAL PROVISIONS

Dependents Eligibility	Spouse, children from birth to end of month in which dependent turns age 26, regardless of student status.

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.
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.
This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 or 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;
• 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 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;
• 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/enhancement, including therapy, supplies, or counseling or prescription drugs;
• Special duty nursing;
• Therapy or rehabilitation other than those listed as covered;
• Weight control services including surgical procedure, 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.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
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.

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PLAN FEATURES	MAXIMUM SAVINGS	STANDARD SAVINGS
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)	None Individual None Family	$1,500 Individual $3,000 Family
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	Covered 100%
Payment Limit (per calendar year)	$400 Individual $800 Family	$2,000 Individual $4,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Referral Requirement	None	None
PREVENTIVE CARE	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%	Covered 100%; deductible waived
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%	Covered 100%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	Covered 100%	Covered 100%; deductible waived
Routine Mammograms	Covered 100%	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%	Covered 100%; deductible waived
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%	Covered 100%; deductible waived
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%	Covered 100%; deductible waived
Colorectal Cancer Screening Recommended: For all members age 45 and over. Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.	Covered 100%	Covered 100%; deductible waived
Routine Eye Exams 1 routine exam per year	$5 copay	$10 copay; deductible waived
Newborn Hearing Testing and Monitoring	$5 copay	$10 copay; deductible waived
Routine Hearing Screening	Covered 100%	Covered 100%; deductible waived
PHYSICIAN SERVICES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$5 office visit copay	$10 office visit copay; deductible waived
Specialist Office Visits	$5 office visit copay	$10 office visit copay; deductible waived
Hearing Exams	Not Covered	Not Covered

Pre-Natal Maternity	Covered 100%	Covered 100%; deductible waived
Walk-in Clinics	$5 office visit copay	$10 office visit copay; 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.

Allergy Testing	$5 office visit copay	$10 copay; deductible waived
Allergy Injections	Covered 100%	Covered 100%; after deductible
DIAGNOSTIC PROCEDURES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Diagnostic X-ray (other than Complex Imaging Services)	Covered 100%	Covered 100%; deductible waived
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 Laboratory	Covered 100%	Covered 100%; deductible waived
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 Outpatient Complex Imaging	Covered 100%	Covered 100%; 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	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Urgent Care Provider	$5 office visit copay	$10 office visit copay; deductible waived
Non-Urgent Use of Urgent Care Provider	$5 office visit copay	$10 office visit copay; deductible waived
Emergency Room Copay waived if admitted	$25 copay	$25 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	Covered 100%; deductible waived
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Inpatient Coverage	Covered 100%	$150 per confinement copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Inpatient	Covered 100%	$150 per confinement copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$5 copay	$10 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%	Covered 100%; deductible waived
SUBSTANCE ABUSE	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Inpatient	Covered 100%	$150 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%	$150 copay; after deductible
Substance Abuse Office Visits	$5 copay	$10 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%	Covered 100%; deductible waived
OTHER SERVICES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Skilled Nursing Facility Limited to 100 days per year	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%	Covered 100%; after deductible

~~**Hospice Care - Inpatient**~~	~~Covered 100%~~	~~Covered 100%; after deductible~~
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Covered 100%	Covered 100%; after deductible
Outpatient Short-Term Rehabilitation Limited to 60 visits per year. Includes speech, physical, occupational therapy	$5 copay	$10 copay; deductible waived
Spinal Manipulation Therapy Limited to 25 visits per year	$5 copay	$10 copay; deductible waived
Habilitative Physical Therapy	Covered 100%	Covered 100%
Habilitative Occupational Therapy	Covered 100%	Covered 100%
Habilitative Speech Therapy	Covered 100%	Covered 100%
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	$5 copay	$10 copay; deductible waived
Autism Applied Behavior Analysis	Covered 100%	Covered 100%
Autism Physical Therapy	Covered 100%	Covered 100%; deductible waived
Autism Occupational Therapy	Covered 100%	Covered 100%; deductible waived
Autism Speech Therapy	Covered 100%	Covered 100%; deductible waived
Durable Medical Equipment	Covered 100%	Covered 100%; deductible waived
Prosthetics	$5 copay	$10 copay; deductible waived
Orthotics	$5 copay	$10 copay; deductible waived
Acupuncture	$5 copay	$10 copay; deductible waived
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered 100%; deductible waived
Hearing Aids 1 hearing aid per ear to $1,000 maximum per ear every 24 months for child to age 16.	$5 copay	$10 copay; deductible waived
Infusion Therapy Administered in the home or physician's office	$5 copay	$10 copay; deductible waived
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Covered 100%	Covered 100%; after deductible
Vision Eyewear $125 Combined maximum for all covered eyeglass lenses, frames and contact lenses	No Charge	No Charge
Transplants	Covered 100%	$150 per confinement copay; after deductible
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%	$150 per confinement copay; after deductible
FAMILY PLANNING	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Applicable cost sharing based on the type of service performed and place of service where rendered	Applicable cost sharing based on the type of service performed and place of service where rendered
Advanced Reproductive Technology (ART) ART coverage includes In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 egg retrievals per lifetime. Coverage includes cryopreservation for iatrogenic infertility only.	Applicable cost sharing based on the type of service performed and place of service where rendered	Applicable cost sharing based on the type of service performed and place of service where rendered
Comprehensive Infertility Services	Applicable cost sharing based on the type of service performed and place of service where rendered	Applicable cost sharing based on the type of service performed and place of service where rendered

Coverage includes Artificial Insemination and Ovulation Induction.

Vasectomy	Covered 100%	Covered 100%
Tubal Ligation	Covered 100%	Covered 100%
PHARMACY	**IN-NETWORK**	
In-network pharmacy expenses apply towards the Maximum Savings tier only.		
Pharmacy Plan Type	Aetna Standard Plan opt out with ACSF	
Payment Limit	$500 Individual $1,000 Family	
Generic Drugs		
Retail	$10 copay	
Mail Order	$10 copay	
Preferred Brand-Name Drugs		
Retail	$20 copay	
Mail Order	$20 copay	
Non-Preferred Brand-Name Drugs		
Retail	$30 copay	
Mail Order	$30 copay	
Retail Out-of-Network Coverage	Not Covered	
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply Standard Opt Out Aetna Insured List	

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Contraceptives covered up to a 6 month supply. Contraceptive copay strategy applies.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral and injectable fertility drugs included (physician charges for injections are not covered under **RX**, medical coverage is limited).
Oral chemotherapy drugs covered 100%
Precertification for specialty drugs included
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 end of month in which dependent turns age 26, regardless of student status.

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Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.
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This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 or 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;
• 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 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;
• 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/enhancement, including therapy, supplies, or counseling or prescription drugs;
• Special duty nursing;
• Therapy or rehabilitation other than those listed as covered;
• Weight control services including surgical procedure, 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.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service 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 pharmacy's 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

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Open Access® Managed Choice® POS - New Jersey
Qualified High Deductible Health Plan

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PLAN FEATURES	IN-NETWORK	OUT-OF-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)	$1,500 Individual $3,000 Family	$1,500 Individual $3,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. 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 apply towards the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the contract year. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	30%
Payment Limit (per calendar year)	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 70th Percentile Facility: 175% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 or 50% of the scheduled benefit amount per occurrence, whichever is less.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	30%; deductible waived
Routine Well Child Exams 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	30%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	Covered 100%; deductible waived	30%; deductible waived
Routine Mammograms	Covered 100%; deductible waived	30%; 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	30%; deductible waived
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	30%; deductible waived
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	30%; deductible waived
Colorectal Cancer Screening	Covered 100%; deductible waived	30%; deductible waived

Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.

Routine Eye Exams 1 routine exam per year.	Covered 100%; deductible waived	30%; after deductible
Newborn Hearing Testing and Monitoring	Covered 100%; deductible waived	30%; after deductible
Routine Hearing Screening	Covered 100%; deductible waived	30%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP)	Covered 100%; after deductible	30%; after deductible
Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	Covered 100%; after deductible	30%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	30%; deductible waived
Walk-in Clinics	Covered 100%; after deductible	30%; after deductible

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.

Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; after deductible	30%; 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 Laboratory	Covered 100%; after deductible	30%; 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 Outpatient Complex Imaging	Covered 100%; after deductible	30%; 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**	**OUT-OF-NETWORK**
Urgent Care Provider	Covered 100%; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care Provider	100%; after deductible	30%; after deductible
Emergency Room	Covered 100%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**

Inpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; after deductible	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	30%; after deductible
Substance Abuse Office Visits	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; after deductible	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 100 days per year	Covered 100%; after deductible	30%; after deductible Limited to 60 days per year
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care Private Duty Nursing not included.	Covered 100%; after deductible	30%; after deductible Limited to 100 visits per year
Hospice Care - Inpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient Limited to 30 eight hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered 100%; after deductible	30%; after deductible
Spinal Manipulation Therapy Limited to 25 visits per year	Covered 100%; after deductible	30%; after deductible
Outpatient Speech Therapy Limited to 30 visits per year	Covered 100%; after deductible	30%; after deductible
Outpatient Physical and Occupational Therapy Limited to 60 visits per year combined.	Covered 100%; after deductible	30%; after deductible
Habilitative Physical Therapy	Covered 100%; after deductible	30%; after deductible
Habilitative Occupational Therapy	Covered 100%; after deductible	30%; after deductible
Habilitative Speech Therapy	Covered 100%; after deductible	30%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	Covered 100%; after deductible	30%; after deductible
Autism Occupational Therapy	Covered 100%; after deductible	30%; after deductible
Autism Speech Therapy	Covered 100%; after deductible	30%; after deductible
Hearing Aids Coverage for all persons age 15 or younger. One hearing aid for each impaired ear limited to $1,000 per hearing aid every 24 months.	Covered 100%; after deductible	30%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	30%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Prosthetics	Covered 100%; after deductible	30%; after deductible
Orthotics	Covered 100%; after deductible	30%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	30%; deductible waived
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense
Infusion Therapy Administered in the home or physician's office	Covered 100%; after deductible	30%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding	Covered 100%; after deductible	30%; after deductible

facility		
Transplants	Covered 100%; after deductible	30%; after deductible
Bariatric Surgery	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Acupuncture	Covered 100%; after deductible	30%; after deductible

FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Advanced Reproductive Technology (ART)	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
ART coverage includes In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 egg retrievals per lifetime. Coverage includes cryopreservation for iatrogenic infertility only.		
Comprehensive Infertility Services	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Vasectomy	Covered 100%; deductible waived	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible

PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Standard Plan opt out with ACSF	
Generic Drugs		
Retail	30%	30% of submitted cost
Mail Order	30%	30% of submitted cost
Preferred Brand-Name Drugs		
Retail	30%	30% of submitted cost
Mail Order	30%	30% of submitted cost
Non-Preferred Brand-Name Drugs		
Retail	30%	30% of submitted cost
Mail Order	30%	30% of submitted cost
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay. Percentage copays will not be doubled	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply Standard Opt Out Aetna Insured List	

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Contraceptives covered up to a 6 month supply. Contraceptive copay strategy applies.
A limited list of over-the-counter medications are covered when filled with a prescription.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 12 tablets a month for males for erectile dysfunction.
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
Oral chemotherapy drugs covered 100%
Precertification for specialty drugs included
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 end of month in which dependent turns 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.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

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.

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
• 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.
• 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/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-**

888-982-3862.
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
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.

aetna

Wayne Township Public Schools
Proposed Effective Date: 07-01-2021
Open Choice® PPO - New Jersey

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	$200 Individual $400 Family	$200 Individual $400 Family
All covered expenses accumulate simultaneously toward both the in-network and out-of-network Deductible. 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. 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.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	20%
Payment Limit (per calendar year)	$5,000 Individual $10,000 Family	No Limit No Limit
All covered expenses accumulate simultaneously toward both the in-network and out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 70th Percentile Facility: 175% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 or 50% of the scheduled benefit amount per occurrence, whichever is less.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	20%; deductible waived
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	20%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	Covered 100%; deductible waived	20%; deductible waived
Routine Mammograms	Covered 100%; deductible waived	20%; 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	20%; deductible waived
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	20%; deductible waived
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	20%; deductible waived
Colorectal Cancer Screening Recommended: For all members age 50 and over. Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.	Covered 100%; deductible waived	20%; deductible waived
Routine Eye Exams 1 routine exam per year.	Covered 100%; deductible waived	20%; after deductible
Routine Hearing Screening	Covered 100%; deductible waived	20%; deductible waived
Newborn Hearing Testing and	Covered 100%; deductible waived	20%; deductible waived

Monitoring		
Medications	Certain over-the-counter preventive medications covered 100% in network.	
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	Covered 100%; after deductible	20%; after deductible
Specialist Office Visits	Covered 100%; after deductible	20%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	20%; deductible waived
Walk-in Clinics	Covered 100%; after deductible	20%; after deductible

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.

Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services)	Covered 100%; after deductible	20%; after deductible
Diagnostic Laboratory	Covered 100%; after deductible	20%; after deductible
Diagnostic Complex Imaging	Covered 100%; after deductible	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	Covered 100%; after deductible	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Covered 100%; after deductible	20%; after deductible
Emergency Room	Covered 100%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Other Mental Health Services	Covered 100%; after deductible	20%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Residential Treatment Facility	Covered 100%; after deductible	20%; after deductible
Substance Abuse Office Visits	Covered 100%; after deductible	20%; after deductible

Your cost sharing applies to all covered benefits incurred during your outpatient visit.

Other Substance Abuse Services	Covered 100%; after deductible	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 120 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Home Health Care	Covered 100%; after deductible	20%; after deductible
Hospice Care - Inpatient	Covered 100%; after deductible	20%; after deductible

Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient Limited to 30 eight hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered 100%; after deductible	20%; after deductible
Spinal Manipulation Therapy Limited to 60 visits per year	Covered 100%; after deductible	20%; after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Physical Therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Occupational Therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Speech Therapy	Covered 100%; after deductible	20%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Covered 100%; after deductible	20%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Covered 100%; deductible waived	20%; after deductible
Autism Physical Therapy	Covered 100%; after deductible	20%; after deductible
Autism Occupational Therapy	Covered 100%; after deductible	20%; after deductible
Autism Speech Therapy	Covered 100%; after deductible	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Prosthetics	Covered 100%; after deductible	20%; after deductible
Orthotics Orthotic Appliances and Services	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	20%; deductible waived
Hearing Aids 1 hearing aid per ear to $1,000 maximum per ear every 24 months for child to age 16.	Covered 100%; after deductible	20%; after deductible
Infusion Therapy Administered in the home or physician's office	Covered 100%; after deductible	20%; 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	Your cost sharing is based on the type of service and where it is performed
Prescription Drugs	Covered 100%	20%; after deductible
Bariatric Surgery	Covered 100%; after deductible	20%; after deductible
Vision Eyewear $110 Combined maximum for all covered eyeglass lenses, frames and contact lenses	No Charge	No Charge
Transplants	Covered 100%; after deductible	20%; after deductible
Acupuncture	Covered 100%; after deductible	20%; after deductible
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-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	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Advanced Reproductive Technology (ART) ART coverage includes In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 egg retrievals per lifetime. Coverage includes cryopreservation for iatrogenic infertility only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vasectomy	Covered 100%; deductible waived	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; deductible waived
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Standard Plan opt out with ACSF	
Payment Limit	$500 Individual	

	$1,000	
Preferred Generic Drugs		
Retail	$10 copay	30% of submitted cost
Mail Order	$10 copay	30% of submitted cost
Preferred Brand-Name Drugs		
Retail	$20 copay	30% of submitted cost
Mail Order	$20 copay	30% of submitted cost
Non-Preferred Generic and Brand-Name Drugs		
Retail	$30 copay	30% of submitted cost
Mail Order	$30 copay	30% of submitted cost
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply Standard Opt Out Aetna Insured List	

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Contraceptives covered up to a 6 month supply. Contraceptive copay strategy applies.
A limited list of over-the-counter medications are covered when filled with a prescription.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 12 tablets a month for males for erectile dysfunction.
Oral chemotherapy drugs covered 100%
Precertification and quantity limits included
Step Therapy included
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 end of month in which dependent turns 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.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of

the production date, it is subject to change.

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.

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
- 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.
- 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/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- 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.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service 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 pharmacy's 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

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

For more information about Aetna plans, refer to **www.aetna.com.**
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.

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Wayne Township Public Schools
Proposed Effective Date: 07-01-2021
Open Access® Managed Choice® POS - New Jersey

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	None Individual None Family	$300 Individual $600 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. 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.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	30%
Payment Limit (per calendar year)	$400 Individual $800 Family	$3,000 Individual $6,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 70th Percentile Facility: 175% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 or 50% of the scheduled benefit amount per occurrence, whichever is less.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%	30%; deductible waived
Routine Well Child Exams 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%	30%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	Covered 100%	30%; deductible waived
Routine Mammograms	Covered 100%	30%; 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%	30%; deductible waived
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%	30%; deductible waived
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%	30%; deductible waived
Colorectal Cancer Screening Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.	Covered 100%	30%; deductible waived
Routine Eye Exams 1 routine exam per year.	$25 copay	30%; after deductible
Newborn Hearing Testing and Monitoring	$25 copay	30%; deductible waived
Medications	Certain over-the-counter preventive medications covered 100% in network.	
Routine Hearing Screening	Covered 100%	30%; deductible waived

PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care Physician (PCP)	$10 office visit copay	30%; after deductible
Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	$25 office visit copay	30%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%	30%; deductible waived
Walk-In Clinics	$10 copay	30%; after deductible

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.

Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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; Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%	30%; 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 Laboratory	Covered 100%	30%; 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 Outpatient Complex Imaging	Covered 100%	30%; 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**	**OUT-OF-NETWORK**
Urgent Care Provider	Covered 100%	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Covered 100%	30%; after deductible
Emergency Room Copay waived if admitted	$100 copay	Same as in-network care
Non-Emergency Care In an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$25 copay	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%	30%; after deductible
Substance Abuse Office Visits	$25 copay	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%	30%; after deductible

OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility Limited to 120 days per year	Covered 100%	30%; 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%	30%; after deductible
Hospice Care - Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient Covered only as part of Home Health Care	Covered 100%	30%; after deductible
Spinal Manipulation Therapy Limited to 30 visits per year	$25 copay	30%; after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy	$10 copay	30%; after deductible
Habilitative Physical Therapy	Covered 100%	30%; after deductible
Habilitative Occupational Therapy	Covered 100%	30%; after deductible
Habilitative Speech Therapy	Covered 100%	30%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	Covered 100%	30%; after deductible
Autism Occupational Therapy	Covered 100%	30%; after deductible
Autism Speech Therapy	Covered 100%	30%; after deductible
Hearing Aids Coverage for all persons age 15 or younger. One hearing aid for each impaired ear limited to $1,000 per hearing aid every 24 months.	$10 copay	30%; after deductible
Durable Medical Equipment	Covered 100%	30%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Prosthetics	$10 copay	30%; after deductible
Orthotics	$10 copay	30%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	30%; deductible waived
Affordable Care Act mandated Women's Contraceptives	Covered 100%	Covered same as any other expense.
Infusion Therapy Administered in the physician's office	$25 copay	30%; after deductible
Infusion Therapy Administered in an outpatient hospital department, freestanding facility or Home	Covered 100%	30%; after deductible
Transplants	Covered 100%	30%; after deductible
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%	30%; after deductible
Acupuncture	$25 copay	30%; after deductible
Vision Eyewear $110 Combined maximum for all covered eyeglass lenses, frames and contact lenses	No Charge	No Charge
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Advanced Reproductive Technology (ART) ART coverage includes In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 egg retrievals per lifetime. Coverage includes cryopreservation for iatrogenic infertility only. . Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services	Your cost sharing is based on the type of service and where it is	Your cost sharing is based on the type of service and where it is

	performed	performed
Coverage includes artificial insemination and ovulation.		
Vasectomy	Covered 100%	30%; after deductible
Tubal Ligation	Covered 100%	30%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Standard Plan opt out with ACSF	
Payment Limit	$500 Individual $1,000	
Preferred Generic Drugs		
Retail	$10 copay	30% of submitted cost
Mail Order	$10 copay	30% of submitted cost
Preferred Brand-Name Drugs		
Retail	$20 copay	30% of submitted cost
Mail Order	$20 copay	30% of submitted cost
Non-Preferred Generic and Brand-Name Drugs		
Retail	$30 copay	30% of submitted cost
Mail Order	$30 copay	30% of submitted cost
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply Standard Opt Out Aetna Insured List	
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Contraceptives covered up to a 6 month supply. Contraceptive copay strategy applies. A limited list of over-the-counter medications are covered when filled with a prescription. Includes sexual dysfunction drugs for females and males, including daily dose, additional 12 tablets a month for males for erectile dysfunction. Oral chemotherapy drugs covered 100% Precertification and quantity limits included Step Therapy included 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 end of month in which they turn 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.

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• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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.

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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
• 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.
• 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/enhancement, including therapy, supplies or counseling or prescription drugs.
• Therapy or rehabilitation other than those listed as covered.
• 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.

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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.

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Wayne Township Public Schools
Proposed Effective Date: 07-01-2021
Open Choice® PPO - New Jersey

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	$200 Individual $400 Family	$200 Individual $400 Family
All covered expenses accumulate simultaneously toward both the in-network and out-of-network Deductible. 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. 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.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	20%
Payment Limit (per calendar year)	$5,000 Individual $10,000 Family	Unlimited Unlimited
All covered expenses accumulate simultaneously toward both the in-network and out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 70th Percentile Facility: 175% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 or 50% of the scheduled benefit amount per occurrence, whichever is less.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	20%; deductible waived
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	20%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	Covered 100%; deductible waived	20%; deductible waived
Routine Mammograms	Covered 100%; deductible waived	20%; 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	20%; deductible waived
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	20%; deductible waived
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	20%; deductible waived
Colorectal Cancer Screening Recommended: For all members age 50 and over. Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.	Covered 100%; deductible waived	20%; deductible waived
Routine Eye Exams 1 routine exam per year.	Covered 100%; deductible waived	20%; after deductible

Routine Hearing Screening	Covered 100%; deductible waived	20%; deductible waived
Newborn Hearing Testing and Monitoring	Covered 100%; after deductible	20%; deductible waived
Medications	Certain over-the-counter preventive medications covered 100% in network.	
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to non-Specialist	Covered 100%; after deductible	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	Covered 100%; after deductible	20%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	20%; deductible waived
Walk-in Clinics	Covered 100%; after deductible	20%; after deductible

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.

Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services)	Covered 100%; after deductible	20%; 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 Laboratory	Covered 100%; after deductible	20%; 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 Complex Imaging	Covered 100%; after deductible	20%; 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**	**OUT-OF-NETWORK**
Urgent Care Provider	Covered 100%; after deductible	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Covered 100%; after deductible	20%; after deductible
Emergency Room	Covered 100%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; after deductible	20%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	20%; after deductible
Substance Abuse Office Visits	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; after deductible	20%; after deductible

OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility Limited to 120 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Home Health Care Private Duty Nursing not included.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Private Duty Nursing - Outpatient Limited to 30 eight hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered 100%; after deductible	20%; after deductible
Spinal Manipulation Therapy Limited to 60 visits per year	Covered 100%; after deductible	20%; after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Physical Therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Occupational Therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Speech Therapy	Covered 100%; after deductible	20%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Covered 100%; after deductible	20%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Covered 100%; after deductible	20%; after deductible
Autism Physical Therapy	Covered 100%; after deductible	20%; after deductible
Autism Occupational Therapy	Covered 100%; after deductible	20%; after deductible
Autism Speech Therapy	Covered 100%; after deductible	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Prosthetics	Covered 100%; after deductible	20%; after deductible
Orthotics Orthotic Appliances and Services	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	20%; deductible waived
Hearing Aids 1 hearing aid per ear to $1,000 maximum per ear every 24 months for child to age 16.	Covered 100%; after deductible	20%; after deductible
Infusion Therapy Administered in the home or physician's office	Covered 100%; after deductible	20%; 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	Your cost sharing is based on the type of service and where it is performed
Prescription Drugs	Covered 100%	20%; after deductible
Vision Eyewear $110 Combined maximum for all covered eyeglass lenses, frames and contact lenses	No Charge	No Charge
Transplants	Covered 100%; after deductible	20%; after deductible
Bariatric Surgery	Covered 100%; after deductible	20%; after deductible
Acupuncture	Covered 100%; after deductible	20%; after deductible

FAMILY PLANNING	IN-NETWORK	OUT-OF-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	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Advanced Reproductive Technology (ART) ART coverage includes In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 egg	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

retrievals per lifetime. Coverage includes cryopreservation for iatrogenic infertility only.

Vasectomy	Covered 100%; deductible waived	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; deductible waived
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Standard Plan opt out with ACSF	
Payment Limit	$500 Individual $1,000	
Preferred Generic Drugs		
Retail	$7.50 copay	30% of submitted cost
Mail Order	$7.50 copay	30% of submitted cost
Brand-Name Drugs		
Retail	$15 copay	30% of submitted cost
Mail Order	$15 copay	30% of submitted cost
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply Standard Opt Out Aetna Insured List	

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Contraceptives covered up to a 6 month supply. Contraceptive copay strategy applies.
A limited list of over-the-counter medications are covered when filled with a prescription.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 12 tablets a month for males for erectile dysfunction.
Oral chemotherapy drugs covered 100%
Precertification and quantity limits included
Step Therapy included
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 end of month in which dependent turns 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.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

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.

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
- 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.
- 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/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- 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.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service 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 pharmacy's 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

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

For more information about Aetna plans, refer to **www.aetna.com.**
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.

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NJ Educators Health Plan
Effective Date: 07-01-2021
Open Access® Managed Choice® POS - New Jersey

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	None Individual None Family	$350 Individual $700 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. 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.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	30%
Payment Limit (per calendar year)	$500 Individual $1,000 Family	$2,000 Individual $5,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 200% of Medicare Facility: 200% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every year up to age 65, 1 exam every year age 65 and older	Covered 100%	Not Covered
Routine Well Child Exams	Covered 100%	Not Covered Immunizations covered at 30%; deductible waived
7 exams the first year, 3 exams the second year, 3 exams the third year, 1 exam per year thereafter to age 22.		
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	Covered 100%	30%; after deductible
Routine Mammograms	Covered 100%	30%; after deductible
Women's Health	Covered 100%	30%; after deductible
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.		
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%	Not Covered
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%	Not Covered
Colorectal Cancer Screening Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.	Covered 100%	Not Covered
Routine Eye Exams 1 routine exam per year. Includes glaucoma test every 5 years for all covered members age 35 and over.	$15 copay	Not Covered
Newborn Hearing Testing and Monitoring	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Routine Hearing Screening	Covered 100%	Not Covered
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$10 office visit copay	30%; after deductible

Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$15 office visit copay	30%; after deductible
~~**Hearing Exams**~~	~~$15 copay~~	~~30%; after deductible~~
Covered to age 16		
Pre-Natal Maternity	Covered 100%	30%; after deductible
Walk-in Clinics	$15 copay	30%; after deductible
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.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Covered 100%	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%	30%; 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 Laboratory	Covered 100%	30%; 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 Outpatient Complex Imaging	Covered 100%	30%; 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**	**OUT-OF-NETWORK**
Urgent Care Provider	$15 office visit copay	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$125 copay	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$15 copay	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%	30%; after deductible
Substance Abuse Office Visits	$15 copay	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered 100% Limited to 120 days per year	30%; after deductible Limited to 60 days per year
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care Private Duty Nursing not included	Covered 100%	30%; after deductible Includes Includes Private Duty Nursing
Hospice Care - Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay. Respite care maximum 10 days per 6 months.		
Hospice Care - Outpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

Private Duty Nursing - Outpatient	10%	Covered as a part of Home Health Care only
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Spinal Manipulation Therapy	$15 copay	30%; after deductible Lesser of $35/visit or 75% of in-network cost/visit
Limited to 30 visits per year		
Outpatient Short-Term Rehabilitation	$15 copay	30%; after deductible for speech and occupational therapy Lesser of $52/visit or 75% of in-network cost/visit for physical therapy only
Includes speech, physical, occupational therapy		
Habilitative Physical Therapy	Covered 100%	30%; after deductible
Habilitative Occupational Therapy	Covered 100%	30%; after deductible
Habilitative Speech Therapy	Covered 100%	30%; after deductible
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 Other Services	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	Covered 100%	30%; after deductible
Autism Occupational Therapy	Covered 100%	30%; after deductible
Autism Speech Therapy	Covered 100%	30%; after deductible
Hearing Aids	$10 copay	30%; after deductible
Coverage for all persons age 15 or younger.		
Durable Medical Equipment	10%	30%; after deductible
Diabetic Supplies – (if not covered under Pharmacy benefit)	10%	30%; after deductible
Prosthetics	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Orthotics	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Fertility Drugs (oral and injectable)	Covered 100%	30%; after deductible
Physician charges included (oral and injectable fertility drugs obtained at a pharmacy are covered under the Rx plan).		
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	$15 copay	30%; 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	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Acupuncture	$15 copay	30%; after deductible Lesser of $60/visit or 75% of in-network cost/visit
Transplants	Covered 100% Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	$15 copay	30%; after deductible
Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Advanced Reproductive Technology (ART)	$15 copay	30%; after deductible
ART coverage includes In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 egg retrievals per lifetime. Coverage includes cryopreservation for iatrogenic infertility.		
Vasectomy	Covered 100%	30%; after deductible
Tubal Ligation	Covered 100%	30%; after deductible

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	New Jersey Educators Health Plan Formulary	
Generic Drugs		
Retail	$5 copay	Copay + amount above the Allowed Amount
Mail Order	$10 copay	Copay + amount above the Allowed Amount
Preferred Brand-Name Drugs		
Retail	$10 copay	Copay + amount above the Allowed Amount
Mail Order	$20 copay	Copay + amount above the Allowed Amount
Non-Preferred Brand-Name Drugs		
Retail	$10 copay	Copay + amount above the Allowed Amount
Mail Order	$20 copay	Copay + amount above the Allowed Amount
Specialty Drugs		
Preferred Specialty	$10 copay	Not Covered
Non-Preferred Specialty	$20 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	1x copay 30 day supply maximum and 2x copay for 31-60 day supply and 3x copay for 61-90 day supply	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	All prescription fills must be through our preferred specialty pharmacy network.	
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited). Oral chemotherapy drugs covered 100% Precertification and quantity limits included Step Therapy included 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.		
Prescription Drug Annual Out of Pocket Maximum	$1,600 Individual $3,200 Family	Not Applicable
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

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.

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
- 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.
- 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/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- 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.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service 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 pharmacy's 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

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

For more information about Aetna plans, refer to **www.aetna.com.**

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.