

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
	ce or supply that is subject to a maximum visit, day, or dollar limitation on a per
year basis, the benefit year begins o	n January 1st unless otherwise mandated. Refer to your plan documents for mor
information.	
Deductible	None Individual
(per calendar year)	None Family
Member Coinsurance	Covered 100%
Applies to all expenses unless other	wise stated.
Payment Limit	\$2,500 Individual
(per calendar year)	\$5,000 Family
	nts may not apply toward the Payment Limit.
Pharmacy expenses do not apply to	wards the Payment Limit.
	esulting from the application of coinsurance percentage, copays, and deductibles
	e used to satisfy the Payment Limit.
	ative Payment Limit for all family members. The family Payment Limit can be me
	; however, no single individual within the family will be subject to more than the
individual Payment Limit amount.	
Lifetime Maximum	
Unlimited except where otherwise in	dicated.
Primary Care Physician Selection	
Referral Requirement	None
PREVENTIVE CARE	IN-NETWORK
	Covered 100%
Routine Adult Physical Exams/	Covered 100%
Immunizations	E 4 average 40 months and CE and older
	5, 1 exam every 12 months age 65 and older
Routine Well Child	Covered 100%
Exams/Immunizations	
	3th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter
to age 22.	
Routine Gynecological Care	Covered 100%
Exams	
1 obgyn exam and pap smear per ye	par
Routine Mammograms	Covered 100%
Women's Health	Covered 100%
	iabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually
	d screening for human immunodeficiency virus, screening and counseling for
	breastfeeding support supplies and counseling
Contracentive methods sterilization	breastfeeding support, supplies and counseling.
	procedures, patient education and counseling. Limitations may apply.
Routine Digital Rectal Exam	procedures, patient education and counseling. Limitations may apply. Covered 100%
Routine Digital Rectal Exam Recommended: For covered males a	procedures, patient education and counseling. Limitations may apply. Covered 100% age 40 and over.
Routine Digital Rectal Exam Recommended: For covered males a Prostate-specific Antigen Test	procedures, patient education and counseling. Limitations may apply. Covered 100% age 40 and over. Covered 100%
Routine Digital Rectal Exam Recommended: For covered males a Prostate-specific Antigen Test Recommended: For covered males a	procedures, patient education and counseling. Limitations may apply. Covered 100% age 40 and over. Covered 100% age 40 and over.
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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 Injections 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. Diagnostic Laboratory Covered 100% 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 Diagnostic Outpatient Complex Imaging Diagnostic Outpatient Complex Imaging EMERGERCY MEDICAL CARCE IN-NETWORK Urgent Care Provider S40 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 EMERGERCY MEDICAL CARCE IN-NETWORK Urgent Care Provider S40 office visit ocpay Non-Urgent Use of Urgent Care Frovider Emergency Room S100 copay Copay waived if admitted Non-Emergency Care in an Not Covered Emergency Use of Ambulance Not Covered Non-Emergency Use of Ambulance Not Covered Inpatient Coverage S250 per day for the first 5 days per confinement, thereafter Covered 100% Non-Emergency Use of Ambulance Not Covered Uning your inpatient stay. Inpatient Maternity Coverage S250 per day for the first 5 days per confinement, thereafter Covered 100% Vour cost sharing applies to all covered benefits incurred during your inpatient stay. Outpatient Busing applies to all covered benefits incurred during your inpatient stay. Outpatient Surgery - Hospital S200 copay Vour cost sharing applies to all covered benefits incurred during your outpatient visit. NETWORK SUBSTANCE ABUSE NETWORK SUBSTA	and physician offices are not considered to be Walk-in Clinics.			
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	rour cost sharing applies to all covered	benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient Covered 100%	Private Duty Nursing - Outpatient	Covered 100%		
Limited to 30 eight hour shifts per year.	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.				
Outpatient Speech Therapy \$20 copay	Outpatient Speech Therapy	\$20 copay		
	Limited to 30 visits per year.			
	Limited to 30 visits per year.			

Outpatient Physical and Occupational Therapy	\$20 copay
Limited to 60 visits per year combined.	
Spinal Manipulation Therapy	\$20 copay
Limited to 25 visits per year 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 Orthotics	\$20 copay
Diabetic Supplies (if not covered	\$20 copay Covered same as any other medical expense.
under Pharmacy benefit) Affordable Care Act mandated	Covered 100%
Women's Contraceptives	Covered 100%
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Hearing Aids	\$20 copay
1 hearing aid per ear to \$1,000 maximu	m per ear every 24 months for child to age 16.
Infusion Therapy	\$40 copay
Administered in the home or	
physician's office	
Infusion Therapy Administered in an outpatient hospital	Your cost sharing is based on the type of service and where it is performed
department or freestanding facility	N. Observe
Vision Eyewear	No Charge
\$125 Combined maximum for all covered eyeglass lenses, frames and	
contact lenses	
Transplants	\$250 per day for the first 5 days per confinement, thereafter Covered 100%
Bariatric Surgery Your cost sharing applies to all covered	\$250 per day for the first 5 days per confinement, thereafter Covered 100% benefits incurred during your inpatient stay.
FAMILY PLANNING	IN-NETWORK
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlyi	ng medical condition only.
Advanced Reproductive	Your cost sharing is based on the type of service and where it is performed
Technology (ART)	
	ion (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer
	 intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 cludes cryopreservation for iatrogenic infertility only.
Comprehensive Infertility Services	Your cost sharing is based on the type of service and where it is performed
Coverage includes Artificial Inseminatio	
Vasectomy	Covered 100%
Tubal Ligation	Covered 100%
PHARMACY	IN-NETWORK
Pharmacy Plan Type	Aetna Standard Plan opt out with ACSF
Generic Drugs	
Retail Mail Order	20% 20%
Preferred Brand-Name Drugs	000/
Retail	20%
Mall Order	20%
Non-Preferred Brand-Name Drugs	200/
Retail Mall Order	20% 20%
	Not Covered
Retail Out-of-Network Coverage Pharmacy Day Supply and Requirement	
Retail	Up to a 30 day supply from Aetna National Network
Notali	For a 31-90 day supply you will be responsible for the Mail Order Drug copay.
	Percentage copays will not be doubled
Mall 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

\$2,500 Individual

Maximum

\$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;
- Intertility 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 overthe-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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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	MAXIMUM SAVINGS	STANDARD SAVINGS
		eximum visit, day, or dollar limitation on a
per year basis, the benefit year begi	ns on January 1st unless otherwis	e mandated. Refer to your plan document
for more information.		
Deductible	None Individual	\$1,500 Individual
(per calendar year)	None Family	\$3,000 Family
Member Coinsurance	Covered 100%	Covered 100%
Applies to all expenses unless other	wise stated.	
Payment Limit	\$400 Individual	\$2,000 Individual
(per calendar year)	\$800 Family	\$4,000 Family
Certain member cost sharing eleme	nts may not apply toward the Payr	ment Limit.
Pharmacy expenses apply towards		
Only those out-of-pocket expenses i	resulting from the application of co	insurance percentage, copays, and
deductibles (except any penalty amo	ounts) may be used to satisfy the F	Payment Limit.
		nembers. The family Payment Limit can be
met by a combination of family mem	bers; however, no single individua	al within the family will be subject to more
than the individual Payment Limit an	nount.	
Lifetime Maximum		
Unlimited except where otherwise in	dicated.	
Primary Care Physician Selection	Optional	Not Applicable
Referral Requirement	None	None
PREVENTIVE CARE	MAXIMUM SAVINGS	STANDARD SAVINGS
Routine Adult Physical Exams/	Covered 100%	Covered 100%; deductible waived
Immunizations	3070100 10070	0010100 10070, 000001010 1101100
1 exam every 12 months up to age 6	55 1 exam every 12 months age 6	5 and older
Routine Well Child	Covered 100%	Covered 100%; deductible waived
Exams/Immunizations	5575154 15575	Covered 10070, deddenble warved
	Sth - 24th months 3 exams 25th -	36th months, 1 exam per 12 months
thereafter to age 22.	5ti - 24ti Montilo, o examo 25ti -	odifficials, readiffer 12 months
Routine Gynecological Care	Covered 100%	Covered 100%; deductible waived
Exams	Covered 100%	Covered 100%, deductible waived
	aar	
1 obgyn exam and pap smear per ye Routine Mammograms	Covered 100%	Covered 100%; deductible waived
Women's Health	Covered 100%	Covered 100%, deductible waived
		Covered 100%, deductible waived
		virus) DNA testing, counseling for sexually
for internamenal and demostic violes		virus) DNA testing, counseling for sexually ficiency virus, screening and counseling
	nce, breastfeeding support, supplie	virus) DNA testing, counseling for sexually ficiency virus, screening and counseling es and counseling.
Contraceptive methods, sterilization	nce, breastfeeding support, supplied procedures, patient education and	virus) DNA testing, counseling for sexually ficiency virus, screening and counseling es and counseling. I counseling. Limitations may apply.
Contraceptive methods, sterilization Routine Digital Rectal Exam	nce, breastfeeding support, supplied procedures, patient education and Covered 100%	virus) DNA testing, counseling for sexually ficiency virus, screening and counseling es and counseling.
Contraceptive methods, sterilization Routine Digital Rectal Exam Recommended: For covered males	nce, breastfeeding support, supplied procedures, patient education and Covered 100% age 40 and over.	virus) DNA testing, counseling for sexually ficiency virus, screening and counseling es and counseling. I counseling. Limitations may apply. Covered 100%; deductible waived
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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

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	Covered 100%	Covered 100%; deductible waived
(other than Complex Imaging Service		
		ician, expenses are covered subject to the
applicable physician's office visit me		
Diagnostic Laboratory	Covered 100%	Covered 100%; deductible waived
		ician, expenses are covered subject to the
applicable physician's office visit me		
Diagnostic Outpatient Complex	Covered 100%	Covered 100%; after deductible
lmaging		
		ician, expenses are covered subject to the
EMERGENCY MEDICAL CARE	MAXIMUM SAVINGS	STANDARD SAVINGS
EMERGENCY MEDICAL CARE		STANDARD SAVINGS \$10 office visit copay; deductible waived
EMERGENCY MEDICAL CARE Urgent Care Provider	MAXIMUM SAVINGS	\$10 office visit copay; deductible
EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care	MAXIMUM SAVINGS \$5 office visit copay	\$10 office visit copay; deductible waived
EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider	MAXIMUM SAVINGS \$5 office visit copay	\$10 office visit copay; deductible waived \$10 office visit copay; deductible
EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room	MAXIMUM SAVINGS \$5 office visit copay \$5 office visit copay	\$10 office visit copay; deductible waived \$10 office visit copay; deductible waived
EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Copay waived if admitted	MAXIMUM SAVINGS \$5 office visit copay \$5 office visit copay	\$10 office visit copay; deductible waived \$10 office visit copay; deductible waived
EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Copay waived if admitted Non-Emergency Care in an	\$5 office visit copay \$5 office visit copay \$25 copay	\$10 office visit copay; deductible waived \$10 office visit copay; deductible waived \$25 copay; deductible waived
EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Copay waived if admitted Non-Emergency Care in an Emergency Room	\$5 office visit copay \$5 office visit copay \$25 copay	\$10 office visit copay; deductible waived \$10 office visit copay; deductible waived \$25 copay; deductible waived Not Covered
EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Copay waived if admitted Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of	## SAVINGS \$5 office visit copay \$5 office visit copay \$25 copay Not Covered	\$10 office visit copay; deductible waived \$10 office visit copay; deductible waived \$25 copay; deductible waived Not Covered
applicable physician's office visit me EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Copay waived if admitted Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance HOSPITAL CARE	MAXIMUM SAVINGS \$5 office visit copay \$5 office visit copay \$25 copay Not Covered Covered 100%	\$10 office visit copay; deductible waived \$10 office visit copay; deductible waived \$25 copay; deductible waived Not Covered Covered 100%; deductible waived

\$150 per confinement copay; after

deductible

Your cost sharing applies to all covered benefits incurred during your inpatient stay.

Covered 100%

Inpatient Coverage

Outpatient Hospital Expenses	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all cover	red benefits incurred during your outpa	
Outpatient Surgery - Hospital	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all cover	red benefits incurred during your outpa	atient visit.
Outpatient Surgery -	Covered 100%	Covered 100%; after deductible
Freestanding Facility		
Your cost sharing applies to all cover	red benefits incurred during your outpa	atient visit.
MENTAL HEALTH SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS
Inpatient	Covered 100%	\$150 per confinement copay; after
		deductible
Your cost sharing applies to all cover	ed benefits incurred during your inpati	
Mental Health Office Visits	\$5 copay	\$10 copay; deductible waived
Your cost sharing applies to all cover	ed benefits incurred during your outpa	tient 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 cover	ed benefits incurred during your inpati	ent 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 cover	ed benefits incurred during your outpa	tient visit.
Other Substance Abuse Services	Covered 100%	Covered 100%; deductible waived
OTHER SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS
Skilled Nursing Facility	Covered 100%	Covered 100%; after deductible
Limited to 100 days per year		
Your cost sharing applies to all cover	ed benefits incurred during your inpati	ent stay.
Home Health Care	Covered 100%	Covered 100%; after deductible

	ed benefits incurred during your inpati-	
Hospice Care - Outpatient	Covered 100%	Covered 100%; after deductible
	ed benefits incurred during your outpa	tient visit.
Private Duty Nursing - Outpatient	Covered 100%	Covered 100%; after deductible
Outpatient Short-Term	\$5 copay	\$10 copay; deductible waived
Rehabilitation		
Limited to 60 visits per year.	al thereas.	
Includes speech, physical, occupation		£40 annum de duratible cominced
Spinal Manipulation Therapy	\$5 copay	\$10 copay; deductible waived
Limited to 25 visits per year	Covered 1009/	Covered 100%
Habilitative Physical Therapy	Covered 100%	Covered 100%
Habilitative Occupational Therapy	Covered 100% Covered 100%	Covered 100%
Habilitative Speech Therapy		
Autism Behavioral Therapy Covered same as any other Outpatier	\$5 copay	\$10 copay; deductible waived
Autism Applied Behavior	Covered 100%	Covered 100%
Autism Applied Benavior 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	Covered same as any other	Covered same as any other
under Pharmacy benefit)	medical expense.	medical expense.
Affordable Care Act mandated	Covered 100%	Covered same as any other
Women's Contraceptives		expense.
Women's Contraceptive drugs	Covered 100%	Covered 100%; deductible waived
pharmacy Hearing Aids 1 hearing aid per ear to \$1,000 maxim	\$5 copay num per ear every 24 months for child	\$10 copay; deductible waived to age 16.
Infusion Therapy Administered in the home or Ohysician's office	\$5 copay	\$10 copay; deductible waived
Infusion Therapy	Covered 100%	Covered 100%; after deductible
Administered in an outpatient		
nospital department or freestanding facility		
Vision Eyewear	No Charge	No Charge
\$125 Combined maximum for all		
covered eyeglass lenses, frames and contact lenses		-
Transplants	Covered 100%	\$150 per confinement copay; after deductible
Bariatric Surgery	Covered 100%	\$150 per confinement copay; after deductible
FAMILY PLANNING	ed benefits incurred during your inpatien MAXIMUM SAVINGS	STANDARD SAVINGS
nfertility Treatment	Applicable cost sharing based on	Applicable cost sharing based on
mornity realment	the type of service performed and place of service where rendered	the type of service performed and place of service where rendered
Diagnosis and treatment of the underl	ying medical condition only.	•
siagnoole and treatment of the under	Applicable cost sharing based on	Applicable cost sharing based on
	rippingation of the mining and the con-	
Advanced Reproductive	the type of service performed and	the type of service performed and
Advanced Reproductive Fechnology (ART)	the type of service performed and place of service where rendered	place of service where rendered
Advanced Reproductive Fechnology (ART) ART coverage includes In vitro fertiliza	the type of service performed and place of service where rendered ation (IVF), zygote intrafallopian transf	place of service where rendered er (ZIFT), gamete intrafallopian
Advanced Reproductive Fechnology (ART) ART coverage includes In vitro fertilizations (GIFT), cryopreserved embryo	the type of service performed and place of service where rendered ation (IVF), zygote intrafallopian transfortransfers, intracytoplasmic sperm inj	place of service where rendered er (ZIFT), gamete intrafallopian ection (ICSI) or ovum microsurgery.
Advanced Reproductive Technology (ART) ART coverage includes In vitro fertilizationsfer (GIFT), cryopreserved embryout included to 4 egg retrievals per lifetime.	the type of service performed and place of service where rendered ation (IVF), zygote intrafallopian transfortransfers, intracytoplasmic sperm injudes cryopreservation	place of service where rendered er (ZIFT), gamete intrafallopian ection (ICSI) or ovum microsurgery. for iatrogenic infertility only.
Advanced Reproductive Technology (ART) ART coverage includes In vitro fertilizations (GIFT), cryopreserved embryo	the type of service performed and place of service where rendered ation (IVF), zygote intrafallopian transfortransfers, intracytoplasmic sperm inj	place of service where rendered er (ZIFT), gamete intrafallopian ection (ICSI) or ovum microsurgery.

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 Sa	vings tier only.
Pharmacy Plan Type	Aetna Standard Plan opt	out with ACSF
Payment Limit	\$500 Individual	
	\$1,000 Family	
Generic Drugs		
Retall	\$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 Require	ments	
Retail	Up to a 30 day supply fro	om Aetna National Network
	For a 31-90 day supply y copay.	ou will be responsible for the Mail Order Drug
Mail Order	A 31-90 day supply from	CVS Caremark® Mail Service Pharmacy
Specialty	Up to a 30 day supply	•

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).

Standard Opt Out Aetna Insured List

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.

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

- 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.

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
Qualified High Deductible Health Plan

PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service	e or supply that is subject to a maximu	ım visit, day, or dollar limitation on a
	ns on January 1st unless otherwise ma	andated. Refer to your plan documents
for more information.		
Deductible (per calendar year)	\$1,500 Individual	\$1,500 Individual
	\$3,000 Family	\$3,000 Family
	eparately toward the in-network and ou	
	uctible must be met prior to benefits be	
	vices, as indicated in the plan, are exclu	uded from charges to meet the
Deductible. Pharmacy expenses app	oly towards the Deductible.	
	mily members will be considered as ha	
	e is no Individual Deductible to satisfy	
Member Coinsurance	Covered 100%	30%
Applies to all expenses unless other		640.000 L III L
Payment Limit (per calendar year)	\$5,000 Individual	\$10,000 Individual
All assessed assessed assessed as	\$10,000 Family	\$20,000 Family
	parately toward the in-network or out-	
	nts may not apply toward the Payment	LIMIT.
Pharmacy expenses apply towards t		rance percentage essential
	esulting from the application of coinsur	
	ounts) may be used to satisfy the Paymative Payment Limit for all family memb	
	ative Payment Limit for all family members; however, no single individual with	
than the individual Payment Limit am		in the family will be subject to more
Lifetime Maximum	iount.	
Unlimited except where otherwise in	dicated	
Payment for Out-of-Network	Not Applicable	Professional: 70 th Percentile
Care**	Not Applicable	Professional. 70° Percentile
Cale		Facility: 175% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -	Орионал	Not Applicable
	of-Network care must be obtained to a	void a reduction in benefits paid for
		ons, Convalescent Facility Admissions,
	d Private Duty Nursing is required - ex	cluded amount applied separately to
	d Private Duty Nursing is required - ex	
each type of expense is \$400 or 50%	of the scheduled benefit amount per o	occurrence, whichever is less.
each type of expense is \$400 or 50% Referral Requirement	of the scheduled benefit amount per one of the scheduled benefit amount per or one of the scheduled benefit amount per or other per or	None None
each type of expense is \$400 or 50% Referral Requirement PREVENTIVE CARE	6 of the scheduled benefit amount per of None IN-NETWORK	None OUT-OF-NETWORK
each type of expense is \$400 or 50% Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/	of the scheduled benefit amount per one of the scheduled benefit amount per or one of the scheduled benefit amount per or other per or	None None
each type of expense is \$400 or 50% Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations	None IN-NETWORK Covered 100%; deductible waived	None OUT-OF-NETWORK 30%; deductible waived
each type of expense is \$400 or 50% Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6	None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and	None OUT-OF-NETWORK 30%; deductible waived
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each type of expense is \$400 or 50% Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6 Routine Well Child Exams 7 exams first 12 months, 3 exams 13	None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and	None OUT-OF-NETWORK 30%; deductible waived d older 30%; deductible waived
each type of expense is \$400 or 50% Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6 Routine Well Child Exams 7 exams first 12 months, 3 exams 13 thereafter to age 22.	None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and Covered 100%; deductible waived th - 24th months, 3 exams 25th - 36th	None OUT-OF-NETWORK 30%; deductible waived d older 30%; deductible waived months, 1 exam per 12 months
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each type of expense is \$400 or 50% Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6 Routine Well Child Exams 7 exams first 12 months, 3 exams 13 thereafter to age 22. Routine Gynecological Care Exams 1 obgyn exam and pap smear per ye Routine Mammograms Women's Health Includes: Screening for gestational d transmitted infections, counseling and for interpersonal and domestic violent Contraceptive methods, sterilization of Routine Digital Rectal Exam Recommended: For covered males at Prostate-specific Antigen Test	None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and Covered 100%; deductible waived th - 24th months, 3 exams 25th - 36th Covered 100%; deductible waived ar Covered 100%; deductible waived covered 100%; deductible waived iabetes, HPV (Human- Papillomavirus) d screening for human immunodeficient ce, breastfeeding support, supplies an procedures, patient education and cour Covered 100%; deductible waived age 40 and over. Covered 100%; deductible waived	Doccurrence, whichever is less. None OUT-OF-NETWORK 30%; deductible waived d older 30%; deductible waived months, 1 exam per 12 months 30%; deductible waived 30%; deductible waived 30%; deductible waived DNA testing, counseling for sexually acy virus, screening and counseling d counseling. Inseling. Limitations may apply.
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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	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	Covered 100%; after deductible	30%; after deductible
	office visit and billed by the physician,	expenses are covered subject to the
applicable physician's office visit mer		
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 mer		
Diagnostic Outpatient Complex	Covered 100%; after deductible	30%; after deductible
Imaging		
	office visit and billed by the physician,	expenses are covered subject to the
applicable physician's office visit mer		
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	Covered 100%; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care	100%; after deductible	30%; after deductible
Provider		
Emergency Room	Covered 100%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of	Not Covered	Not Covered
Ambulance		
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all cover	ed benefits incurred during your inpati-	ent stay.
Inpatient Maternity Coverage	Covered 100%; after deductible	30%; after deductible
(includes delivery and postpartum		
care)		
Your cost sharing applies to all cover	ed benefits incurred during your inpation	
Outpatient Hospital Expenses	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all cover	ed benefits incurred during your outpa	tient visit.
Outpatient Surgery - Hospital	Covered 100%; after deductible	30%; after deductible
	ed benefits incurred during your outpa	tient visit.
Outpatient Surgery -	Covered 100%; after deductible	30%; after deductible
Freestanding Facility		
	ed benefits incurred during your outpa	tient visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK

Inpatient	Covered 100%; after deductible	30%; after deductible
	red benefits incurred during your inpat	
Mental Health Office Visits	Covered 100%; after deductible	30%; after deductible
	red benefits incurred during your outpa	atient 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 cove	red benefits incurred during your inpat	ient stay.
Residential Treatment Facility	Covered 100%; after deductible	30%; after deductible
Substance Abuse Office Visits	Covered 100%; after deductible	30%; after deductible
	red benefits incurred during your outpa	
Other Substance Abuse Services	Covered 100%; after deductible	30%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	Covered 100%; after deductible	30%; after deductible
Limited to 100 days per year		Limited to 60 days per year
	red benefits incurred during your inpat	
Home Health Care	Covered 100%; after deductible	30%; after deductible Limited to 100 visits per year
Private Duty Nursing not included.		Limited to 100 visits per year
Hospice Care - Inpatient	Covered 100%; after deductible	30%; after deductible
	red benefits incurred during your inpat	
Hospice Care - Outpatient	Covered 100%; after deductible	30%; after deductible
	red benefits incurred during your outpa	
Private Duty Nursing - Outpatient	Covered 100%; after deductible	30%; after deductible
Limited to 30 eight hour shifts per ye		
	of up to 8 hours will be deemed to be o	
Spinal Manipulation Therapy	Covered 100%; after deductible	30%; after deductible
Limited to 25 visits per year		
Outpatient Speech Therapy	Covered 100%; after deductible	30%; after deductible
Limited to 30 visits per year		000/ 6 1 1 111
Outpatient Physical and	Covered 100%; after deductible	30%; after deductible
Occupational Therapy		
Limited to 60 visits per year combine		200/ s offer deducatible
Habilitative Physical Therapy Habilitative Occupational	Covered 100%; after deductible Covered 100%; after deductible	30%; after deductible 30%; after deductible
Therapy	Covered 100%, after deductible	50%, after deductible
Habilitative Speech Therapy	Covered 100%; after deductible	30%; after deductible
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
Addisin Denavioral Therapy	Health	Health
Covered same as any other Outpatie		
Autism Applied Behavior	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
Analysis	Health Other Services	Health Other Services
	ent Mental Health Other Services bene	fit
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	Covered 100%; after deductible	30%; after deductible
	ounger. One hearing aid for each impa	aired ear limited to \$1,000 per hearing
aid every 24 months.		
Durable Medical Equipment	Covered 100%; after deductible	30%; after deductible
Diabetic Supplies - (if not covered	Covered same as any other	Covered same as any other
under Pharmacy benefit)	medical expense.	medical expense.
Prosthetics	Covered 100%; after deductible	30%; after deductible
Orthotics	Covered 100%; after deductible	30%; after deductible
Women's Contraceptive drugs	Covered 100%; deductible waived	30%; deductible waived
and devices not obtainable at a		
Pharmacy Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other
Women's Contraceptives	Covered 10070, deductible walved	expense
Infusion Therapy	Covered 100%; after deductible	30%; after deductible
Administered in the home or	Co. 5.00 10070, ditor doddolible	
physician's office		
Infusion Therapy	Covered 100%; after deductible	30%; after deductible
Administered in an outpatient		
hospital department or freestanding		

Covered 100%; after deductible	
	30%; after deductible
Covered 100%; after deductible	30%; after deductible
Covered 100%; after deductible	30%; after deductible
IN_NETWORK	OUT-OF-NETWORK
	Your cost sharing is based on the
	type of service and where it is
	performed
	periorined
	Your cost sharing is based on the
	type of service and where it is
performed	performed
	for iatrogenic infertility only.
	Your cost sharing is based on the
	type of service and where it is
	performed
	applies to all procedures covered by
	200/
	30%; after deductible
	30%; after deductible OUT-OF-NETWORK
	00.0
the deductible before any benefits are	considered for payment under the
Aetna Standard Plan opt out with AC	· CE
Aetha Standard Flan Opt Out With AC	
30%	30% of submitted cost
Li	IN-NETWORK Your cost sharing is based on the type of service and where it is performed rlying medical condition only. Your cost sharing is based on the type of service and where it is performed relying medical condition only. Your cost sharing is based on the type of service and where it is performed reation (IVF), zygote intrafallopian transport transfers, intracytoplasmic sperming. Coverage includes cryopreservation Your cost sharing is based on the type of service and where it is performed tion and ovulation. Lifetime maximum a ited by law. Covered 100%; deductible waived Covered 100%; deductible waived IN-NETWORK the deductible before any benefits are

Mail Order 30%
Pharmacy Day Supply and Requirements

Preferred Brand-Name Drugs

Non-Preferred Brand-Name Drugs

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

30% of submitted cost

30% of submitted cost

30% of submitted cost

30% of submitted cost

copay.

Retail 30%

Retail 30%

Mail Order 30%

Percentage copays will not be doubled

Specialty

Mail Order A 31-90 day supply from CVS Caremark® Mail Service Pharmacy

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. © 2014 Aetna Inc.

October 2021 Page 1



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 su	pply that is subject to a maximum visit,	day, or dollar limitation on a per year
basis, the benefit year begins on January 1	st unless otherwise mandated. Refer to	your plan documents for more
information.		
Deductible (per calendar year)	\$200 Individual	\$200 Individual
	\$400 Family	\$400 Family
All covered expenses accumulate simultane		
Unless otherwise indicated, the deductible r	nust be met prior to benefits being paya	ble.
Member cost sharing for certain services, as		n charges to meet the Deductible.
Pharmacy expenses do not apply towards to		
The family Deductible is a cumulative Deduction		
combination of family members; however, n	o single individual within the family will b	e subject to more than the individual
Deductible amount.		
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherwise sta	ated.	
Payment Limit (per calendar year)	\$5,000 Individual	No Limit
	\$10,000 Family	No Limit
All covered expenses accumulate simultane	ously toward both the in-network and or	
Certain member cost sharing elements may	not apply toward the Payment Limit.	
Pharmacy expenses do not apply towards the		
Only those out-of-pocket expenses resulting		centage, copays, and deductibles
(except any penalty amounts) may be used		A TANAH TANA
The family Payment Limit is a cumulative Pa		family Payment Limit can be met by a
combination of family members; however, no	o single individual within the family will h	e subject to more than the individual
Payment Limit amount.		The state of the s
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 70th Percentile
r aymont for out-of-Network Care	Not Applicable	Facility: 175% of Medicare
Primary Care Physician Selection	Ontional	
Certification Requirements -	Optional	Not Applicable
Certification Requirements -		
	ank ages maret ha abtained to arraid a re-	dunting in honofts:- for the t
Certification for certain types of Out-of-Netw	ork care must be obtained to avoid a rec	duction in benefits paid for that care.
Certification for certain types of Out-of-Netw Certification for Hospital Admissions, Treatm	nent Facility Admissions, Convalescent I	Facility Admissions, Home Health Care,
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Monitoring		
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, gener	al physician, family practitioner or pediatricia	n.
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 bene	Covered 100%; after deductible	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered bene		
Outpatient Hospital Expenses Your cost sharing applies to all covered bene	Covered 100%; after deductible fits incurred during your outpatient visit.	20%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered bene	Covered 100%; after deductible	20%; after deductible
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered bene	fits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
npatient Your cost sharing applies to all covered bene	Covered 100%; after deductible	20%; after deductible
Mental Health Office Visits	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered bene	fits incurred during your outpatient visit	2079, diter deductible
Other Mental Health Services	Covered 100%; after deductible	20%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
npatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered bene		2070, aitel 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	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered to	enefits incurred during your inpatient stay	у.
Home Health Care	Covered 100%; after deductible	20%; after deductible
Hospice Care - Inpatient	Covered 100%: after deductible	20%: after deductible

Hospice Care - Outpatient	efits incurred during your inpatient stay Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered bene	efits incurred during your outpatient vis	it.
Private Duty Nursing - Outpatient	Covered 100%; after deductible	20%; after deductible
Limited to 30 eight hour shifts per year.		
Each period of private duty nursing of up to 8	8 hours will be deemed to be one priva-	te duty nursing shift.
Spinal Manipulation Therapy	Covered 100%; after deductible	20%; after deductible
Limited to 60 visits per year		o morno a financia i monte e e e e e e e e e e e e e e e e e e
Outpatient Short-Term Rehabilitation	Covered 100%; after deductible	20%; after deductible
ncludes speech, physical, occupational ther	ару	DH OF TO AN AND CONTROL OF
Habilitative Physical Therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Occupational Therapy	Covered 100%; after deductible	20%; after deductible
labilitative Speech Therapy	Covered 100%; after deductible	20%; after deductible
Autism Behavioral Therapy	Covered 100%; after deductible	20%; after deductible
Covered same as any other Outpatient Ment		Control of Americani
Autism Applied Behavior Analysis	Covered 100%; deductible waived	20%; after deductible
Covered same as any other Outpatient Ment	tal Health Other Services benefit	
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
Ourable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Prosthetics	Covered 100%; after deductible	20%; after deductible
Orthotics	Covered 100%; after deductible	20%; after deductible
Orthotic Appliances and Services	Tarana Taran and adductions	_s/v, and doddonoio
Diabetic Supplies - (if not covered under	Covered same as any other medical	Covered same as any other medic
Pharmacy benefit)	expense.	expense.
Affordable Care Act mandated Women's	Covered 100%; deductible waived	Covered same as any other
Contraceptives	Covered 10070, academoio Walved	expense.
Nomen's Contraceptive drugs and	Covered 100%; deductible waived	20%; deductible waived
levices not obtainable at a pharmacy	corollar 10070, addadable Halfed	2070, deddelible walved
learing Aids	Covered 100%; after deductible	20%; after deductible
hearing aid per ear to \$1,000 maximum per		6
nfusion Therapy	Covered 100%; after deductible	20%; after deductible
Administered in the home or physician's	Corona tooyof and addedible	2070, and doddonbie
office		
nfusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
lepartment or freestanding facility	performed	performed
Prescription Drugs	Covered 100%	20%; after deductible
MAIRA EN		
Sariatric Surgery	Covered 100%; after deductible	20%; after deductible
	No Charge	No Charge
/ision Eyewear	No Charge	No Charge
ision Eyewear Combined maximum for all covered	No Charge	No Charge
ision Eyewear 110 Combined maximum for all covered yeglass lenses, frames and contact		No Charge
lision Eyewear 110 Combined maximum for all covered yeglass lenses, frames and contact enses	No Charge Covered 100%; after deductible	20%; after deductible
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Tision Eyewear 110 Combined maximum for all covered yeglass lenses, frames and contact enses Transplants Cupuncture AMILY PLANNING	Covered 100%; after deductible Covered 100%; after deductible IN-NETWORK	20%; after deductible
Tision Eyewear 110 Combined maximum for all covered yeglass lenses, frames and contact enses Transplants Cupuncture AMILY PLANNING	Covered 100%; after deductible Covered 100%; after deductible	20%; after deductible 20%; after deductible OUT-OF-NETWORK
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Tision Eyewear 110 Combined maximum for all covered yeglass lenses, frames and contact enses Transplants Cupuncture AMILY PLANNING Infertility Treatment	Covered 100%; after deductible Covered 100%; after deductible IN-NETWORK Your cost sharing is based on the type of service and where it is performed	20%; after deductible 20%; after deductible OUT-OF-NETWORK Your cost sharing is based on the
Tision Eyewear 110 Combined maximum for all covered yeglass lenses, frames and contact enses Transplants Cupuncture AMILY PLANNING Infertility Treatment	Covered 100%; after deductible Covered 100%; after deductible IN-NETWORK Your cost sharing is based on the type of service and where it is performed	20%; after deductible 20%; after deductible OUT-OF-NETWORK Your cost sharing is based on the type of service and where it is
rision Eyewear 110 Combined maximum for all covered 1110 Combined maximum for all covered 1111 Combined 1111 Combin	Covered 100%; after deductible Covered 100%; after deductible IN-NETWORK Your cost sharing is based on the type of service and where it is performed	20%; after deductible 20%; after deductible OUT-OF-NETWORK Your cost sharing is based on the type of service and where it is performed
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Vision Eyewear 1110 Combined maximum for all covered eyeglass lenses, frames and contact enses Transplants Acupuncture TAMILY PLANNING Infertility Treatment Diagnosis and treatment of the underlying meteomprehensive Infertility Services	Covered 100%; after deductible Covered 100%; after deductible IN-NETWORK Your cost sharing is based on the type of service and where it is performed edical condition only. Your cost sharing is based on the	20%; after deductible 20%; after deductible OUT-OF-NETWORK Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
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	\$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-N	ame 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 overthe-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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October 2021



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 max	ximum visit, day, or dollar limitation on a per year
information.	uary 1st unless otherwise mandat	ed. Refer to your plan documents for more
Deductible (per calendar year)	None Individual None Family	\$300 Individual \$600 Family
Unless otherwise indicated, the deduc	ctible must be met prior to benefit	s being payable.
Member cost sharing for certain servi	ces, as indicated in the plan, are	excluded from charges to meet the Deductible.
Pharmacy expenses do not apply tow	ards the Deductible.	
The family Deductible is a cumulative	Deductible for all family members	s. The family Deductible can be met by a
	ever, no single individual within the	e family will be subject to more than the individual
Deductible amount.		
Member Coinsurance	Covered 100%	30%
Applies to all expenses unless otherw		
Payment Limit (per calendar year)	\$400 Individual	\$3,000 Individual
All	\$800 Family	\$6,000 Family
All covered expenses accumulate sep		
Certain member cost sharing element		ent Limit.
Pharmacy expenses do not apply tow	ards the Payment Limit.	
		nsurance percentage, copays, and deductibles
(except any penalty amounts) may be		
		embers. The family Payment Limit can be met by a family will be subject to more than the individual
Payment Limit amount.	ver, no single individual within the	aniny will be subject to more than the individual
Lifetime Maximum		
Unlimited except where otherwise indi	icated	
Payment for Out-of-Network Care**		Desferational with Description
Payment for Out-of-Network Care	Not Applicable	Professional: 70th Percentile
D-1	0-41	Facility: 175% of Medicare
rimary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Out-of	t-Notwork care must be obtained (
Continuation for contain types of Out-of	i-iverwork care illust be obtained	to avoid a reduction in benefits paid for that care.
Certification for Hospital Admissions,	Treatment Facility Admissions, Co	onvalescent Facility Admissions, Home Health
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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	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
Alloray Injections	your cost sharing is based on the	performed
Allergy Injections	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; Covered 100% when an	performed
	office visit charge is not applicable.	performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	Covered 100%	30%; after deductible
f performed as a part of a physician office		
applicable physician's office visit member		
Diagnostic Laboratory	Covered 100%	30%; after deductible
f performed as a part of a physician office		ses are covered subject to the
applicable physician's office visit member		
Diagnostic Outpatient Complex	Covered 100%	30%; after deductible
maging		
f performed as a part of a physician office	visit and billed by the physician, expen-	ses are covered subject to the
pplicable physician's office visit member		<u> </u>
MERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Jrgent Care Provider	Covered 100%	30%; after deductible
Non-Urgent Use of Urgent Care	Covered 100%	30%; after deductible
Provider		
mergency Room	\$100 copay	Same as in-network care
Copay waived if admitted		
lon-Emergency Care In an	Not Covered	Not Covered
Emergency Room		
mergency Use of Ambulance	Covered 100%	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
IOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient Coverage	Covered 100%	30%; after deductible
our cost sharing applies to all covered be		
npatient Maternity Coverage (includes	Covered 100%	30%; after deductible
delivery and postpartum care)		
our cost sharing applies to all covered be		
Outpatient Hospital Expenses	Covered 100%	30%; after deductible
our cost sharing applies to all covered be		
Outpatient Surgery - Hospital	Covered 100%	30%; after deductible
our cost sharing applies to all covered be		
Outpatient Surgery - Freestanding	Covered 100%	30%; after deductible
Facility Your cost sharing applies to all covered be	mofite incurred during your outpotions wi	eit
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
npatient	Covered 100%	30%; after deductible
npatient /our cost sharing applies to all covered be		
Mental Health Office Visits	\$25 copay	30%; after deductible
our cost sharing applies to all covered be		
Other Mental Health Services	Covered 100%	30%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
		30%; after deductible
	COVERED TITLE	oo /o, alter deddelible
patient	Covered 100%	
npatient our cost sharing applies to all covered be	nefits incurred during your inpatient sta	у.
npatient /our cost sharing applies to all covered be tesidential Treatment Facility	nefits incurred during your inpatient star Covered 100%	y. 30%; after deductible
npatient 'our cost sharing applies to all covered be Residential Treatment Facility Substance Abuse Office Visits 'our cost sharing applies to all covered be	nefits incurred during your inpatient sta Covered 100% \$25 copay	y. 30%; after deductible 30%; after deductible

OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	Covered 100%	30%; after deductible
Limited to 120 days per year		Limited to 60 days per year
Your cost sharing applies to all covered b		
Home Health Care	Covered 100%	30%; after deductible
Hospice Care - Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered b		
Hospice Care - Outpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered b		
Private Duty Nursing - Outpatient	Covered 100%	30%; after deductible
Covered only as part of Home Health Car Spinal Manipulation Therapy		200/ office deductible
Limited to 30 visits per year	\$25 copay	30%; after deductible
Outpatient Short-Term Rehabilitation	\$10 copay	30%; after deductible
Includes speech, physical, occupational th		200/ 6 1 1 1111
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	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient Me		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
502 757 171 179	Health Other Services	Health Other Services
Covered same as any other Outpatient Me		
Autism Physical Therapy	Covered 100%	30%; after deductible
Autism Occupational Therapy	Covered 100%	30%; after deductible
Autism Speech Therapy	Covered 100%	30%; after deductible
learing Aids	\$10 copay	30%; after deductible
Coverage for all persons age 15 or young		limited to \$1,000 per hearing aid every
24 months.	on one nouning air for odor impanou our	miniod to \$1,000 per ficaling and every
Durable Medical Equipment	Covered 100%	30%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Prosthetics	\$10 copay	30%; after deductible
Orthotics	\$10 copay	30%; after deductible
Ditilotics	ф 10 сорау	30%, alter deductible
Women's Contraceptive drugs and	Covered 100%	30%; deductible waived
devices not obtainable at a pharmacy Affordable Care Act mandated	Covered 100%	Coursed comments and the
	Covered 100%	Covered same as any other expense.
Nomen's Contraceptives	COE access	200/ - 6 - 4 - 4 - 4 - 4 - 4
nfusion Therapy	\$25 copay	30%; after deductible
Administered in the physician's office	014000/	000/ 0 1 1 1111
nfusion Therapy Administered in an outpatient hospital department, freestanding facility or	Covered 100%	30%; after deductible
Home		
Fransplants	Covered 100%	30%; after deductible
Bariatric Surgery	Covered 100%	30%; after deductible
our cost sharing applies to all covered be		
Acupuncture	\$25 copay	30%; after deductible
/ision Eyewear		
110 Combined maximum for all	No Charge	No Charge
covered eyeglass lenses, frames and contact lenses		
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
	AND THE PARTY OF T	
nfertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
Negrosis and treatment of the underlying	performed	performed
Diagnosis and treatment of the underlying		Vaus and the death of the state of the
dunneed Denveding Toolers	Varia cost charles in bessel the	
	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
ART)	type of service and where it is performed	type of service and where it is performed
ART) ART coverage includes In vitro fertilization	type of service and where it is performed (IVF), zygote intrafallopian transfer (ZIFT	type of service and where it is performed), gamete intrafallopian transfer
ART) ART coverage includes In vitro fertilization GIFT), cryopreserved embryo transfers, ir	type of service and where it is performed (IVF), zygote intrafallopian transfer (ZIFT stracytoplasmic sperm injection (ICSI) or o	type of service and where it is performed), gamete intrafallopian transfer ovum microsurgery. Limited to 4 egg
ART) ART coverage includes In vitro fertilization GIFT), cryopreserved embryo transfers, in etrievals per lifetime. Coverage includes of the coverage of the cove	type of service and where it is performed (IVF), zygote intrafallopian transfer (ZIFT stracytoplasmic sperm injection (ICSI) or or cryopreservation for iatrogenic infertility or	type of service and where it is performed), gamete intrafallopian transfer ovum microsurgery. Limited to 4 egg
ART) ART coverage includes In vitro fertilization GIFT), cryopreserved embryo transfers, in etrievals per lifetime. Coverage includes or occedures covered by any of our plans ex	type of service and where it is performed (IVF), zygote intrafallopian transfer (ZIFT stracytoplasmic sperm injection (ICSI) or cryopreservation for latrogenic infertility of cept where prohibited by law.	type of service and where it is performed (), gamete intrafallopian transfer ovum microsurgery. Limited to 4 egg only Lifetime maximum applies to all
Advanced Reproductive Technology ART) ART coverage includes In vitro fertilization GIFT), cryopreserved embryo transfers, in etrievals per lifetime. Coverage includes procedures covered by any of our plans excomprehensive Infertility Services	type of service and where it is performed (IVF), zygote intrafallopian transfer (ZIFT stracytoplasmic sperm injection (ICSI) or or cryopreservation for iatrogenic infertility or	type of service and where it is performed), gamete intrafallopian transfer ovum microsurgery. Limited to 4 egg

Table Control -		
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-Na	me Drugs	

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.

performed

30% of submitted cost

30% of submitted cost

Mail Order A 31-90 day supply from CVS Caremark® Mail Service Pharmacy

Specialty Up to a 30 day supply

Retail \$30 copay

Mail Order \$30 copay

performed

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.

- 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 overthe-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.

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 Choice® PPO - New Jersey

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
	r supply that is subject to a maximum visit	
basis, the benefit year begins on Janua	ry 1st unless otherwise mandated. Refer t	o your plan documents for more
information.		
Deductible (per calendar year)	\$200 Individual	\$200 Individual
	\$400 Family	\$400 Family
All covered expenses accumulate simul	taneously toward both the in-network and	
	ble must be met prior to benefits being pay	
	s, as indicated in the plan, are excluded fr	
Pharmacy expenses do not apply towar		om onarges to meet the beddetible.
	eductible for all family members. The fami	ly Deductible can be met by a
	er, no single individual within the family wil	
Deductible amount.	or, no single individual within the fairing will	be subject to more than the individual
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherwise		2076
Payment Limit (per calendar year)	\$5,000 Individual	I Indicate at
Payment Limit (per calendar year)		Unlimited
All assumed assumes assumed at a single	\$10,000 Family	Unlimited
	taneously toward both the in-network and	out-or-network Payment Limit.
	may not apply toward the Payment Limit.	
Pharmacy expenses do not apply towar		6 1971 o 1979
	Iting from the application of coinsurance p	ercentage, copays, and deductibles
(except any penalty amounts) may be u		
The family Payment Limit is a cumulativ	e Payment Limit for all family members. To	ne ramily Payment Limit can be met by
	ver, no single individual within the family v	vill be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indica	ated.	
Payment for Out-of-Network Care**	Not Applicable	Professional: 70th Percentile
		Facility: 175% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
	letwork care must be obtained to avoid a	reduction in benefits paid for that care
	eatment Facility Admissions, Convalescen	
	ursing is required - excluded amount appli	
	amount per occurrence, whichever is less	
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	20%; deductible waived
Immunizations	Covered 100%, deductible waived	20 %, deductible waived
	evam even 12 menths age 65 and older	
Routine Well Child	exam every 12 months age 65 and older Covered 100%; deductible waived	
	Covered 100%, deductible waived	20%; deductible waived
Exams/Immunizations	0.445	. 4
	24th months, 3 exams 25th - 36th months	s, 1 exam per 12 months thereafter to
age 22.	0 14000/ 1-7 121	000/ 1 1 1 2 2 1
Routine Gynecological Care Exams	Covered 100%; deductible waived	20%; deductible waived
1 obgyn exam and pap smear per year		
Routine Mammograms	Covered 100%; deductible waived	20%; deductible waived
Women's Health	Covered 100%; deductible waived	20%; deductible waived
	etes, HPV (Human- Papillomavirus) DNA t	
	creening for human immunodeficiency viru	
interpersonal and domestic violence, bre	eastfeeding support, supplies and counseli	ng.
	cedures, patient education and counseling	
Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; deductible waived
Recommended: For covered males age		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; deductible waived
Recommended: For covered males age		2070, academbie Walved
Colorectal Cancer Screening	Covered 100%; deductible waived	20%; deductible waived
	and over. Coverage includes Sigmoidosc	
	and over coverage includes digitiologic	opy every o years for all covered
members age 45 and over.		
Routine Eye Exams	Covered 100%; deductible waived	20%; after deductible
1 routine exam per year.		

Routine Hearing Screening	Covered 100%; deductible waived	20%; deductible waived
Newborn Hearing Testing and	Covered 100%; after deductible	20%; deductible waived
Monitoring		:- ichteld:
Medications	Certain over-the-counter preventive n	nedications 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, gen	eral physician, family practitioner or pedia	trician.
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.

physician offices are not considered to	be Walk-in Clinics.	repries, amberetory danginar comore, and
Allergy Testing	Your cost sharing is based on the type	Your cost sharing is based on the type
	of service and where it is performed	of service and where it is performed
Allergy Injections	Your cost sharing is based on the type	Your cost sharing is based on the type
	of service and where it is performed.	of service and where it is performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	Covered 100%; after deductible	20%; after deductible
(other than Complex Imaging		
Services)		
	ice visit and billed by the physician, expen	ises are covered subject to the
applicable physician's office visit memb		000/
Diagnostic Laboratory	Covered 100%; after deductible	20%; after deductible
	ice visit and billed by the physician, expen	ises are covered subject to the
applicable physician's office visit memb Diagnostic Complex Imaging	Covered 100%; after deductible	200/
	ice visit and billed by the physician, expen	20%; after deductible
applicable physician's office visit member		ises are covered subject to the
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT OF NETWORK
Urgent Care Provider	Covered 100%; after deductible	OUT-OF-NETWORK
Non-Urgent Use of Urgent Care	Covered 100%, after deductible	20%; after deductible
Provider	Covered 100%, after deductible	20%; after deductible
Emergency Room	Covered 100%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
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
	benefits incurred during your inpatient sta	
Inpatient Maternity Coverage	Covered 100%; after deductible	20%; after deductible
(includes delivery and postpartum	Governou 10070, anter deductible	2070, arter doddelible
care)		
	benefits incurred during your inpatient sta	IV.
Outpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatient vi	
Outpatient Surgery - Hospital	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatient vi	
Outpatient Surgery - Freestanding	Covered 100%; after deductible	20%; after deductible
Facility		
Your cost sharing applies to all covered	benefits incurred during your outpatient vi	isit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your inpatient sta	
Mental Health Office Visits	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatient vi	
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
	benefits incurred during your inpatient sta	
Residential Treatment Facility	Covered 100%; after deductible	20%; after deductible
Substance Abuse Office Visits	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatient vi	
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	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your inpatient sta	ıv.
Home Health Care Private Duty Nursing not included.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Inpatient	Covered 100%; after deductible benefits incurred during your inpatient sta	20%; after deductible
Hospice Care - Outpatient	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatient v	
Private Duty Nursing - Outpatient Limited to 30 eight hour shifts per year.	Covered 100%; after deductible	20%; after deductible
	p to 8 hours will be deemed to be one priv	
Spinal Manipulation Therapy Limited to 60 visits per year	Covered 100%; after deductible	20%; after deductible
Outpatient Short-Term Rehabilitation	Covered 100%; after deductible	20%; after deductible
Includes speech, physical, occupational 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 100%; after deductible	20%; after deductible
Covered same as any other Outpatient		2070 41101 202201110
Autism Applied Behavior Analysis	Covered 100%; after deductible	20%; after deductible
Covered same as any other Outpatient		
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 Orthotics	Covered 100%; after deductible	20%; after deductible
Orthotics Orthotic Appliances and Services	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	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	Covered 100%; after deductible	20%; after deductible
	n per ear every 24 months for child to age	
Infusion Therapy Administered in the home or physician's office	Covered 100%; after deductible	20%; after deductible
Infusion Therapy	Your cost sharing is based on the type	Your cost sharing is based on the type
Administered in an outpatient hospital department or freestanding facility	of service and where it is performed	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	Your cost sharing is based on the type	Your cost sharing is based on the type
Diagnosis and treatment of the underlying	of service and where it is performed	of service and where it is performed
Comprehensive Infertility Services	Your cost sharing is based on the type	Your cost sharing is based on the type
Coverage includes artificial insemination	of service and where it is performed and ovulation. Lifetime maximum applies	of service and where it is performed
our plans except where prohibited by lav		
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
	on (IVF), zygote intrafallopian transfer (ZIF intracytoplasmic sperm injection (ICSI) or	

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 AC	SF
Payment Limit	\$500 Individual \$1,000	
Preferred Generic Drugs		
Retail	\$7.50 copay	30% of submitted cost
Mall Order	\$7.50 copay	30% of submitted cost
Brand-Name Drugs		
Retail	\$15 copay	30% of submitted cost
	\$15 copay	30% of submitted cost
Pharmacy Day Supply and Requirer	nents	
	Up to a 30 day supply from Aetha Na	tional Network

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.

Mall 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.

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Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

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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.

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- · 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 overthe-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, 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.

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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
year basis, the benefit year begins o	ce or supply that is subject to a maximum on January 1st unless otherwise mandate	n visit, day, or dollar limitation on a per ed. Refer to your plan documents for more
information. Deductible (per calendar year)	None Individual	\$350 Individual
I lalone otherwise indicated the ded	None Family uctible must be met prior to benefits bein	\$700 Family
Member cost sharing for certain serv	vices, as indicated in the plan, are exclud	g payable. led from charges to meet the Deductible.
	wards the Deductible. e Deductible for all family members. The vever, no single individual within the fami	
Member Coinsurance	Covered 100%	30%
Applies to all expenses unless other		30 %
Payment Limit (per calendar year)	\$500 Individual	\$2,000 Individual
, , , , , , , , , , , , , , , , , , , ,	\$1,000 Family	\$5,000 Family
All covered expenses accumulate se	eparately toward the in-network and out-	
Certain member cost sharing elemer	nts may not apply toward the Payment Li	mit.
Pharmacy expenses do not apply to	wards the Payment Limit.	
	esulting from the application of coinsurar e used to satisfy the Payment Limit.	nce percentage, copays, and deductibles
The family Payment Limit is a cumul	ative Payment Limit for all family membe	ers. 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 in		
Payment for Out-of-Network Care	Not Applicable	Professional: 200% of Medicare
		Facility: 200% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
care. Certification for Hospital Admis	of-Network care must be obtained to avo sions, Treatment Facility Admissions, Co ate Duby Nursing is required.	
care. Certification for Hospital Admis Health Care, Hospice Care and Priva Referral Requirement	ssions, Treatment Facility Admissions, Co ate Duty Nursing Is required. None	onvalescent Facility Admissions, Home None
care. Certification for Hospital Admis Health Care, Hospice Care and Priva Referral Requirement PREVENTIVE CARE	ssions, Treatment Facility Admissions, Co ate Duty Nursing Is required. None IN-NETWORK	None OUT-OF-NETWORK
care. Certification for Hospital Admis Health Care, Hospice Care and Priva Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations	ssions, Treatment Facility Admissions, Co ate Duty Nursing Is required. None IN-NETWORK Covered 100%	onvalescent Facility Admissions, Home None
care. Certification for Hospital Admis Health Care, Hospice Care and Priva Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every year up to age 65, 1 ex	ssions, Treatment Facility Admissions, Co ate Duty Nursing Is required. None IN-NETWORK Covered 100% xam every year age 65 and older	None OUT-OF-NETWORK Not Covered
care. Certification for Hospital Admis Health Care, Hospice Care and Priva Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every year up to age 65, 1 ex	ssions, Treatment Facility Admissions, Co ate Duty Nursing Is required. None IN-NETWORK Covered 100%	None OUT-OF-NETWORK Not Covered Not Covered Immunizations covered at 30%;
care. Certification for Hospital Admis Health Care, Hospice Care and Priva Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every year up to age 65, 1 ex Routine Well Child Exams	ssions, Treatment Facility Admissions, Co ate Duty Nursing Is required. None IN-NETWORK Covered 100% xam every year age 65 and older Covered 100%	None OUT-OF-NETWORK Not Covered Immunizations covered at 30%; deductible waived
care. Certification for Hospital Admis Health Care, Hospice Care and Priva Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every year up to age 65, 1 ex Routine Well Child Exams 7 exams the first year, 3 exams the s	ssions, Treatment Facility Admissions, Coate Duty Nursing Is required. None IN-NETWORK Covered 100% exam every year age 65 and older Covered 100% second year, 3 exams the third year, 1 ex	None OUT-OF-NETWORK Not Covered Immunizations covered at 30%; deductible waived kam per year thereafter to age 22.
care. Certification for Hospital Admis Health Care, Hospice Care and Priva Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every year up to age 65, 1 ex Routine Well Child Exams 7 exams the first year, 3 exams the s Routine Gynecological Care Exams	ssions, Treatment Facility Admissions, Coate Duty Nursing Is required. None IN-NETWORK Covered 100% xam every year age 65 and older Covered 100% second year, 3 exams the third year, 1 ex	None OUT-OF-NETWORK Not Covered Immunizations covered at 30%; deductible waived
care. Certification for Hospital Admis Health Care, Hospice Care and Priva Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every year up to age 65, 1 ex Routine Well Child Exams 7 exams the first year, 3 exams the s Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	ssions, Treatment Facility Admissions, Coate Duty Nursing Is required. None IN-NETWORK Covered 100% xam every year age 65 and older Covered 100% second year, 3 exams the third year, 1 examples.	None OUT-OF-NETWORK Not Covered Not Covered Immunizations covered at 30%; deductible waived cam per year thereafter to age 22. 30%; after deductible
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Specialist Office Visits	neral physician, family practitioner or ped \$15 office visit copay	30%; after deductible
tearing-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 heasupermarket or other retail store; and	alth care facilities that (a) may be located d (b) provide limited medical care and se ncy rooms, the outpatient department of	I in or with a pharmacy, drug store, rvices on a scheduled or unscheduled
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 If performed as a part of a physician applicable physician's office visit me	Covered 100% office visit and billed by the physician, exmber cost sharing.	30%; after deductible expenses are covered subject to the
Diagnostic Laboratory	Covered 100%	30%; after deductible
If performed as a part of a physician	office visit and billed by the physician, ex	xpenses are covered subject to the
applicable physician's office visit me		000/
	Covered 100% office visit and billed by the physician, ex	30%; after deductible expenses are covered subject to the
applicable physician's office visit me EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	\$15 office visit copay	30%; after deductible
Non-Urgent Use of Urgent Care	Not Covered	Not Covered
Provider	6405	S
Emergency Room Copay waived if admitted Non-Emergency Care in an	\$125 copay Not Covered	Same as in-network care Not Covered
Emergency Room	1101 0010100	1131 0010100
Emergency Use of Ambulance	10%	Same as in-network care
Non-Emergency Use of Ambulanc		Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient Coverage Your cost sharing applies to all cover	Covered 100% red benefits incurred during your inpatien	30%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum	Covered 100%	30%; after deductible
care) Your cost sharing applies to all cover	red benefits incurred during your inpatien	nt stav.
Outpatient Hospital Expenses	Covered 100%	30%; after deductible
Your cost sharing applies to all cover	red benefits incurred during your outpatie	ent visit.
Outpatient Surgery - Hospital	Covered 100%	30%; after deductible
Your cost sharing applies to all cover Outpatient Surgery - Freestanding	red benefits incurred during your outpatie Covered 100%	ant visit. 30%; after deductible
Facility Your cost sharing applies to all cover	red benefits incurred during your outpatie	
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
npatient	Covered 100%	30%; after deductible
Mental Health Office Visits	red benefits incurred during your inpatien \$15 copay red benefits incurred during your outpatie	30%; after deductible
Other Mental Health Services	Covered 100%	30%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
npatient	Covered 100%	30%; after deductible
	red benefits incurred during your inpatien	
Residential Treatment Facility Substance Abuse Office Visits	Covered 100%	30%; after deductible
	\$15 copay red benefits incurred during your outpatie	30%; after deductible ont visit.
Other Substance Abuse Services	Covered 100%	30%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	Covered 100%	30%; after deductible
form and shall are the first	Limited to 120 days per year	Limited to 60 days per year
∕our cost sharing applies to all cover Home Health Care	ed benefits incurred during your inpatien Covered 100%	
Private Duty Nursing not included	COVERED TOU?	30%; after deductible Includes Includes Private Duty Nursing
Hospice Care - Inpatient	Covered 100%	30%; after deductible
	red benefits incurred during your inpatien 5 months.	
Hospice Care - Outpatient	Covered 100%	30%; after deductible

Private Duty Nursing - Outpatient	10%	Covered as a part of Home Health Care only
Calculate duty nursing of	up to 8 hours will be deemed to be one	
Spinal Manipulation Therapy Limited to 30 visits per year	\$15 copay	30%; after deductible Lesser of \$35/visit or 75% of in- network cost/visit
Outpatient Short-Term	£15 copey	30%; after deductible for speech and
Rehabilitation	\$15 copay	occupational therapy Lesser of \$52/visit or 75% of in- network cost/visit for physical therapy only
Includes speech, physical, occupation		200/ - 4 4- 44-1-1-
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 Outpatien	Refer to MBH Outpatient Mental Health t Mental Health benefit	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services t Mental Health Other Services benefit	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	\$10 copay	30%; after deductible
Coverage for all persons age 15 or you	unger.	
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	Your cost sharing is based on the type of service and where it is
	performed	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) Physician charges included (oral and in Women's Contraceptive drugs and	njectable fertility drugs obtained at a pha Covered 100%	30%; after deductible irmacy are covered under the Rx plan). Covered same as any other expense
devices not obtainable at a		
	0 1400%	
pharmacy Affordable Care Act mandated Women's Contraceptives	Covered 100%	
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office	\$15 copay	Covered same as any other expense 30%; after deductible
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital	\$15 copay Your cost sharing is based on the type of service and where it is	30%; after deductible Your cost sharing is based on the type of service and where it is
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility	\$15 copay Your cost sharing is based on the type of service and where it is performed	30%; after deductible Your cost sharing is based on the type of service and where it is performed
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered	30%; after deductible Your cost sharing is based on the type of service and where it is performed Not Covered
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay	30%; after deductible Your cost sharing is based on the type of service and where it is performed
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or ohysician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear Acupuncture	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay Covered 100%	30%; after deductible Your cost sharing is based on the type of service and where it is performed Not Covered 30%; after deductible Lesser of \$60/visit or 75% of innetwork cost/visit 30%; after deductible
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear Acupuncture Transplants	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay Covered 100% Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Your cost sharing is based on the type of service and where it is performed Not Covered 30%; after deductible Lesser of \$60/visit or 75% of innetwork cost/visit 30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or ohysician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear Acupuncture Transplants Bariatric Surgery	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay Covered 100% Preferred coverage is provided at an IOE contracted facility only. Covered 100%	30%; after deductible Your cost sharing is based on the type of service and where it is performed Not Covered 30%; after deductible Lesser of \$60/visit or 75% of innetwork cost/visit 30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. 30%; after deductible
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or ohysician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear Acupuncture Transplants Bariatric Surgery Your cost sharing applies to all covered	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay Covered 100% Preferred coverage is provided at an IOE contracted facility only. Covered 100% benefits incurred during your inpatient of the coverage provided at the non-preferrere.	30%; after deductible Your cost sharing is based on the type of service and where it is performed Not Covered 30%; after deductible Lesser of \$60/visit or 75% of innetwork cost/visit 30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. 30%; after deductible stay.
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear Acupuncture Transplants Bariatric Surgery Your cost sharing applies to all covered Out of Area Dependents	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay Covered 100% Preferred coverage is provided at an IOE contracted facility only. Covered 100% benefits incurred during your inpatient of the coverage provided at the non-preferre provider is not available.	30%; after deductible Your cost sharing is based on the type of service and where it is performed Not Covered 30%; after deductible Lesser of \$60/visit or 75% of innetwork cost/visit 30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. 30%; after deductible stay. d benefit level of the plan if in-network
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear Acupuncture Transplants Bariatric Surgery Your cost sharing applies to all covered Out of Area Dependents	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay Covered 100% Preferred coverage is provided at an IOE contracted facility only. Covered 100% d benefits incurred during your inpatient of the coverage provided at the non-preferre provider is not available. IN-NETWORK	30%; after deductible Your cost sharing is based on the type of service and where it is performed Not Covered 30%; after deductible Lesser of \$60/visit or 75% of innetwork cost/visit 30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. 30%; after deductible stay. d benefit level of the plan if in-network
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Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear Acupuncture Transplants Bariatric Surgery Your cost sharing applies to all covered Out of Area Dependents FAMILY PLANNING Infertility Treatment Diagnosis and treatment of the underly Comprehensive Infertility Services	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay Covered 100% Preferred coverage is provided at an IOE contracted facility only. Covered 100% benefits incurred during your inpatients. Coverage provided at the non-preferre provider is not available. IN-NETWORK Your cost sharing is based on the type of service and where it is performed ing medical condition only. \$15 copay	Your cost sharing is based on the type of service and where it is performed Not Covered 30%; after deductible Lesser of \$60/visit or 75% of innetwork cost/visit 30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. 30%; after deductible stay. d benefit level of the plan if in-network OUT-OF-NETWORK Your cost sharing is based on the type of service and where it is performed 30%; after deductible
Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear Acupuncture Transplants Bariatric Surgery Your cost sharing applies to all covered Out of Area Dependents FAMILY PLANNING Infertility Treatment Diagnosis and treatment of the underly Comprehensive Infertility Services Coverage includes artificial insemination	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay Covered 100% Preferred coverage is provided at an IOE contracted facility only. Covered 100% d benefits incurred during your inpatients. Coverage provided at the non-preferre provider is not available. IN-NETWORK Your cost sharing is based on the type of service and where it is performed ing medical condition only. \$15 copay and ovulation. Lifetime maximum applications.	Your cost sharing is based on the type of service and where it is performed Not Covered 30%; after deductible Lesser of \$60/visit or 75% of innetwork cost/visit 30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. 30%; after deductible stay. d benefit level of the plan if in-network OUT-OF-NETWORK Your cost sharing is based on the type of service and where it is performed 30%; after deductible
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Affordable Care Act mandated Women's Contraceptives Infusion Therapy Administered in the home or physician's office Infusion Therapy Administered in an outpatient hospital department or freestanding facility Vision Eyewear Acupuncture Transplants Bariatric Surgery Your cost sharing applies to all covered Out of Area Dependents FAMILY PLANNING Infertility Treatment Diagnosis and treatment of the underly Comprehensive Infertility Services Coverage includes artificial insemination out plans except where prohibited by la Advanced Reproductive Technology (ART) ART coverage includes In vitro fertilization	\$15 copay Your cost sharing is based on the type of service and where it is performed Not Covered \$15 copay Covered 100% Preferred coverage is provided at an IOE contracted facility only. Covered 100% d benefits incurred during your inpatient: Coverage provided at the non-preferre provider is not available. IN-NETWORK Your cost sharing is based on the type of service and where it is performed ing medical condition only. \$15 copay and ovulation. Lifetime maximum applications.	Your cost sharing is based on the type of service and where it is performed Not Covered 30%; after deductible Lesser of \$60/visit or 75% of innetwork cost/visit 30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. 30%; after deductible stay. d benefit level of the plan if in-network OUT-OF-NETWORK Your cost sharing is based on the type of service and where it is performed 30%; after deductible ies to all procedures covered by any of 30%; after deductible
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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	New Jersey Educators Heal	th 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	A	
Preferred Specialty		Not Covered
Non-Preferred Specialty		Not Covered
Pharmacy Day Supply and Requirem		
Retail	1x copay 30 day supply max copay for 61-90 day supply	simum and 2x copay for 31-60 day supply and 3x
Mail Order	A 31-90 day supply from CV	S Caremark® Mail Service Pharmacy
Specialty	All prescription fills must be	through our preferred specialty pharmacy
	network.	
Plan Includes: Diabetic supplies and (
Oral and injectable fertility drugs includ coverage is limited).	ed (physician charges for inject	ctions are not covered under RX, medical
Oral chemotherapy drugs covered 100	%	
Precertification and quantity limits inclu		
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	Not Applicable
	\$3,200 Family	
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth t	to age 26 regardless of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

- · 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 overthe-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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