



North Brunswick Township Board of Education – \$20/\$35
Proposed Effective Date: 7/1/2020
Open Access® Managed Choice® POS - New Jersey

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None	\$300 Individual
	None	\$600 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance	None	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$6,520 Individual	\$3,000 Individual
	\$13,040 Family	\$6,000 Family

All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.
Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.
The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.

Lifetime Maximum

Unlimited except where otherwise indicated.

Primary Care Physician Selection	Optional	Not Applicable
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Certification Requirements

Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required.

Referral Requirement	None	None
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PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations (Age and frequency schedules apply)	Covered 100%	30%; deductible waived
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%	30%; deductible waived
Routine Gynecological Care Exams Includes routine tests and related lab fees. 1 exam per calendar year	Covered 100%	30%; deductible waived
Routine Mammograms Recommended: One baseline mammogram for covered females age 35-39, no frequency limit for routine mammograms for covered females age 40 and over.	Covered 100%	30%; deductible waived
Women's Health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%	30%; deductible waived
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%	30%; deductible waived



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Prostate-specific Antigen Test	Covered 100%	30%; deductible waived
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%	30%; deductible waived
Recommended: For all members age 50 and over.		
Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.		
Routine Eye Exams	\$35 copay	30%; after deductible
1 routine exam per calendar year. Includes glaucoma test every 5 years for all covered members age 35 and over.		
Newborn Hearing Testing	Covered 100%	30%; deductible waived
Medications	Certain over-the-counter preventive medications covered 100% in network.	
Routine Hearing Screening	Covered 100%	30%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	\$20 copay	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	\$35 copay	30%; after deductible
Teladoc	\$0 copay	Not Covered
Audiometric Hearing Exam	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%	Covered according to standard claim practice.
Walk-in Clinics	\$20 copay	30%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered	30%; after deductible
Allergy Injections	Covered 100%	30%; after deductible
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	Covered 100%	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	Covered 100%	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Outpatient Complex Imaging	Covered 100%	30%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	\$50 copay	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$50 copay	Same as in-network care
Copay waived if admitted		
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	100%	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered



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HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%	30%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%	30%; after deductible
Outpatient Hospital Expenses The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%	30%; after deductible
Outpatient Surgery - Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%	30%; after deductible
Outpatient Surgery - Freestanding Facility The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%	30%; after deductible
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%	30%; after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$35 copay	30%; after deductible
ALCOHOL/DRUG ABUSE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%	30%; after deductible
Residential Treatment Facility	Covered 100%	30%; after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$35 copay	30%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Convalescent Facility Overall combined In and Out of network max 120 days per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%	30%; after deductible
Home Health Care Limited to 60 visits per calendar year	Covered 100%	30%; after deductible
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%	30%; after deductible
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%	30%; after deductible
Private Duty Nursing - Outpatient Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered 100%	30%; after deductible



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Outpatient Short-Term Rehabilitation	\$35 copay	30%; after deductible
Autism Behavioral Therapy	Covered 100%	30%; after deductible
Autism Applied Behavior Analysis	Covered 100%	30%; after deductible
Autism Physical Therapy	Covered 100%	30%; after deductible
Autism Occupational Therapy	Covered 100%	30%; after deductible
Autism Speech Therapy	Covered 100%	30%; after deductible
Spinal Manipulation Therapy Limited to 30 visits per calendar year.	\$35 copay	30%; after deductible
Hearing Aids Coverage for all persons age 15 or younger. One hearing aid for each impaired ear limited to \$1,000 per hearing aid every 24 months.	\$35 copay	30%; after deductible
Durable Medical Equipment	Covered 100%	30%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Prosthetics	Covered 100%	30%; after deductible
Orthotics	\$20 copay	30%; after deductible
Fertility Drugs (oral and injectable)	Covered 100%	30%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other expense.
Generic FDA-approved Women's Contraceptives	Covered 100%	Covered same as any other expense.
Transplants	Covered 100% Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Covered 100%	30%; after deductible
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Coverage includes Artificial Insemination and Ovulation Induction.		



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Advanced Reproductive Technology (ART)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Covered at 4 completed egg retrievals per lifetime		
Vasectomy	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered

GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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. 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.
- 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.
- Pharmacy Copays
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
- Therapy or rehabilitation other than those listed as covered.