aetna™

**Perth Amboy Board of Education**
Proposed Effective Date: 07-01-2022
Open Access® Managed Choice® POS - New Jersey

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

| PLAN FEATURES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Benefit Limitations** - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information. | | |
| **Deductible** (per calendar year) | $400 Individual<br>$800 Family | $600 Individual<br>$1,200 Family |
| All covered expenses accumulate separately toward the in-network and out-of-network Deductible.<br>Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.<br>Pharmacy expenses do not apply towards the Deductible.<br>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**<br>Applies to all expenses unless otherwise stated. | 10% | 40% |
| **Payment Limit** (per calendar year) | $1,000 Individual<br>$2,000 Family | $2,000 Individual<br>$4,000 Family |
| All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit.<br>Certain member cost sharing elements may not apply toward the Payment Limit.<br>Pharmacy expenses apply towards the Payment Limit.<br>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.<br>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**<br>Unlimited except where otherwise indicated. | | |
| **Payment for Out-of-Network Care**** | Not Applicable | Professional: 110% of Medicare<br>Facility: 140% of Medicare |
| **Primary Care Physician Selection** | Optional | Not Applicable |
| **Certification Requirements -**<br>Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 or 50% of the scheduled benefit amount per occurrence, whichever is less. | | |
| **Referral Requirement** | None | None |
| **PREVENTIVE CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Routine Adult Physical Exams/ Immunizations**<br>1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older | Covered 100%; deductible waived | 40%; after deductible |
| **Routine Well Child Exams**<br>7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22. | Covered 100%; deductible waived | 40%; after deductible |
| **Routine Gynecological Care Exams**<br>1 obgyn exam and pap smear per year | Covered 100%; deductible waived | 40%; after deductible |

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| **Routine Mammograms** | Covered 100%; deductible waived | Covered 100%; deductible waived |
| **Women's Health** | Covered 100%; deductible waived | 40%; after deductible |
| Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | | |
| **Routine Digital Rectal Exam** | Covered 100%; deductible waived | 40%; after deductible |
| Recommended: For covered males age 40 and over. | | |
| **Prostate-specific Antigen Test** | Covered 100%; deductible waived | 40%; after deductible |
| Recommended: For covered males age 40 and over. | | |
| **Colorectal Cancer Screening** | Covered 100%; deductible waived | 40%; after deductible |
| Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over. | | |
| **Routine Eye Exams** | Covered 100%; deductible waived | 40%; after deductible |
| 1 routine exam per 24 months. | | |
| **Newborn Hearing Testing and Monitoring** | $30 copay; deductible waived | 40%; deductible waived |
| **Routine Hearing Screening** | Covered 100%; deductible waived | 40%; after deductible |
| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Office Visits to Primary Care Physician (PCP)** | $15 office visit copay; deductible waived | 40%; after deductible |
| **Specialist Office Visits**<br><br>Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP. | $30 office visit copay; deductible waived | 40%; after deductible |
| **Hearing Exams** | Not Covered | Not Covered |
| **Pre-Natal Maternity** | Covered 100%; deductible waived | 40%; after deductible |
| **Walk-in Clinics** | $15 copay; deductible waived<br>**Designated Walk-in Clinics**<br>Covered 100%; deductible waived | 40%; 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** | 10%; after deductible | 40%; after deductible |
| If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |
| **Diagnostic Laboratory** | 10%; after deductible | 40%; after deductible |
| If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |

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| **Diagnostic Outpatient Complex Imaging** | 10%; after deductible | 40%; after deductible |
| If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Urgent Care Provider** | $25 office visit copay; deductible waived | 30%; after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered | Not Covered |
| **Emergency Room**<br>Copay waived if admitted | $50 copay; deductible waived | 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** | 10%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Inpatient Maternity Coverage** (includes delivery and postpartum care) | 10%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Outpatient Hospital Expenses** | 10%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Outpatient Surgery - Hospital** | 10%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Outpatient Surgery - Freestanding Facility** | 10%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 10%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Mental Health Office Visits** | $30 copay; deductible waived | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other Mental Health Services** | Covered 100%; deductible waived | 40%; after deductible |
| **SUBSTANCE ABUSE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 10%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Residential Treatment Facility** | 10%; after deductible | 40%; after deductible |
| **Substance Abuse Office Visits** | $30 copay; deductible waived | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other Substance Abuse Services** | Covered 100%; deductible waived | 40%; after deductible |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled Nursing Facility** | 10%; after deductible | 40%; after deductible |
| Limited to 60 days per year<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Home Health Care** | 10%; after deductible | 40%; after deductible |
| Limited to 60 visits per year<br>Home health care services include private duty nursing<br>Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less. | | |

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| **Hospice Care - Inpatient** | 10%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Hospice Care - Outpatient** | 10%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Private Duty Nursing** - Outpatient | Covered as part of Home Health Care | Covered as part of Home Health Care |
| Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. | | |
| **Spinal Manipulation Therapy** | $25 copay; deductible waived | 40%; after deductible |
| **Outpatient Short-Term Rehabilitation** | $20 copay; deductible waived | 40%; after deductible |
| Includes speech, physical, occupational therapy | | |
| **Habilitative Physical Therapy** | Covered 100%; deductible waived | 40%; after deductible |
| **Habilitative Occupational Therapy** | Covered 100%; deductible waived | 40%; after deductible |
| **Habilitative Speech Therapy** | Covered 100%; deductible waived | 40%; after deductible |
| **Autism Behavioral Therapy** | Refer to MBH Outpatient Mental Health | Refer to MBH Outpatient Mental Health |
| Covered same as any other Outpatient Mental Health benefit | | |
| **Autism Applied Behavior Analysis** | Refer to MBH Outpatient Mental Health Other Services | Refer to MBH Outpatient Mental Health Other Services |
| Covered same as any other Outpatient Mental Health Other Services benefit | | |
| **Autism Physical Therapy** | Covered 100%; deductible waived | 40%; after deductible |
| **Autism Occupational Therapy** | Covered 100%; deductible waived | 40%; after deductible |
| **Autism Speech Therapy** | Covered 100%; deductible waived | 40%; after deductible |
| **Hearing Aids** | $15 copay; deductible waived | 40%; after deductible |
| Limited to:1 hearing aid per ear to $1,000 maximum per ear every 24 months for child to age 16. | | |
| **Durable Medical Equipment** | 10%; after deductible | 40%; 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%; deductible waived | 40%; after deductible |
| **Orthotics** | Covered 100%; deductible waived | 40%; after deductible |
| **Women's Contraceptive drugs and devices not obtainable at a pharmacy** | Covered 100%; deductible waived | Covered same as any other expense. |
| **Affordable Care Act mandated Women's Contraceptives** | Covered 100%; deductible waived | Covered same as any other expense. |
| **Infusion Therapy** Administered in the home or physician's office | $30 copay; deductible waived | 40%; after deductible |
| **Infusion Therapy** Administered in an outpatient hospital department or freestanding facility | 10%; after deductible | 40%; after deductible |
| **Vision Eyewear** | Not Covered | Not Covered |
| **Transplants** | 10%; after deductible Preferred coverage is provided at an IOE contracted facility only. | 40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. |
| **Bariatric Surgery** | Not Covered | Not Covered |
| **Acupuncture** Limited to 10 visits per year | $15 copay; deductible waived | 40%; after deductible |
| **Out of Area Dependents** | Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available. | |

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| FAMILY PLANNING | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Infertility Treatment** | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| Diagnosis and treatment of the underlying medical condition only. | | |
| **Comprehensive Infertility Services** | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law. | | |
| **Advanced Reproductive Technology (ART)** | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| ART coverage includes In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 egg retrievals per lifetime. Coverage includes cryopreservation for iatrogenic infertility only. | | |
| **Vasectomy** | Covered 100%; deductible waived | 40%; after deductible |
| **Tubal Ligation** | Covered 100%; deductible waived | 40%; after deductible |
| **PHARMACY** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Pharmacy Plan Type** | Standard Opt Out Plan with ACSF Plan - Aetna | |
| **Generic Drugs** | | |
| **Retail** | $10 copay | $10 copay |
| **Mail Order** | $10 copay | $10 copay |
| **Brand-Name Drugs** | | |
| **Retail** | $15 copay | $15 copay |
| **Mail Order** | $15 copay | $15 copay |
| **Pharmacy Day Supply and Requirements** | | |
| **Retail** | Up to a 30 day supply from Aetna National Network<br>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<br>Standard Opt Out Aetna Insured List | |
| **Choose Generics with Dispense as Written (DAW) override** - The member pays the applicable copay only, if the physician requires brand-name. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price. | | |
| **Plan Includes:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.<br>Contraceptives covered up to a 6 month supply. Contraceptive copay strategy applies.<br>A limited list of over-the-counter medications are covered when filled with a prescription.<br>Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).<br>Oral chemotherapy drugs covered 100%<br>Precertification for specialty drugs included<br>Seasonal Vaccinations covered 100% in-network<br>Preventive Vaccinations covered 100% in-network<br>Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network. | | |
| **Prescription Drug Annual Out of Pocket Maximum** | $4,950 Individual<br>$9,900 Family | Not Applicable |
| **GENERAL PROVISIONS** | | |
| **Dependents Eligibility** | Spouse, children from birth to age 26 regardless of student status. | |

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**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.

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• 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.