

Important information about organ and tissue donation

Each year, we're required to send you informational materials about organ and tissue donation and registration. This is required* as your health benefits plan is written in New Jersey.

For information on how to make an anatomical gift, including information on the registration of a gift in the Donate Life New Jersey registry, please use the following contact information, depending on where you live:

If you live in northern or central New Jersey, contact:

New Jersey Sharing Network
691 Central Avenue, New Providence, NJ 07974
Phone: **(800) 742-7365**
Email: info@NJSharingNetwork.org
Web address: **www.NJSharingNetwork.org**

If you live in southern New Jersey, contact:

Gift of Life Donor Program
401 N. 3rd Street, Philadelphia, PA 19123
Phone: **(800) DONORS-1 (800) 366-6771**
Email: info@donors1.org
Web address: **www.donors1.org**

If you live in another state, please find the organization for your state online at:
https://organdonor.gov/awareness/organizations/local-opo.html

If you have any questions, please call our customer service department at the phone number on the back of your ID card. Thank you.

***This notice is sent in compliance with Chapter 220 of the New Jersey Laws of 2017.**
Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company of New York and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

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Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Preferred provider organization (PPO) medical plan

Certificate of coverage

Prepared exclusively for:

Policyholder:	Monroe Township Board of Education
Policyholder number:	GP-152709
Plan name:	Open Access Managed Choice Plan
Booklet-certificate:	2
Group policy effective date:	July 1, 2020
Plan effective date:	July 1, 2020
Plan issue date:	May 28, 2021
Plan revision effective date:	July 1, 2021

This Certificate is not in place of insurance for Worker's Compensation. This certificate is governed by applicable federal law and the laws of New Jersey

Underwritten by Aetna Life Insurance Company

aetna™

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Schedule of benefits Issued with your certificate of coverage

Welcome

At Aetna, your health goals lead the way, so we're joining you to put them first. We believe that whatever you decide to do for your health, you can do it with the right support. And no matter where you are on this personal journey, it's our job to enable you to feel the joy of achieving your best health.

Welcome to Aetna.

Introduction

This is your certificate of coverage or "certificate." It describes your **covered services** – what they are and how to get them. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Along with the group policy, they describe your Aetna plan. Each may have amendments attached to them. These change or add to the document. This certificate takes the place of any others sent to you before.

It's really important that you read the entire certificate and your schedule of benefits.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the *Coordination of benefits, Effect of prior plan coverage* section.

If you need help or information, see the *Contact us* section below.

How we use words

When we use:

- "You" and "your" we mean you and any covered dependents (if your plan allows dependent coverage)
- "Us," "we," and "our" we mean Aetna
- Words that are in bold, we define them in the *Glossary* section

Contact us

For questions about your plan, you can contact us by:

- Calling the toll-free number on your ID card
- Logging in to the Aetna website at https://www.aetna.com/
- Writing us at 151 Farmington Ave, Hartford, CT 06156

Your member website is available 24/7. With your member website, you can:

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a **provider**, research **providers**, care and treatment options
- View and manage claims
- Find information on health and wellness

Your ID card

Show your ID card each time you get **covered services** from a **provider**. Only members on your plan can use your ID card. We will mail you your ID card. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary one using the Aetna website.

Coverage and exclusions

Providing covered services

Your plan provides **covered services**. These are:

- Described in this section.
- Not listed as an exclusion in this section or the *General plan exclusions* section.
- Not beyond any limits in the schedule of benefits.
- **Medically necessary**. See the *How your plan works – Medical necessity and precertification requirements* section and the *Glossary* for more information.

For **covered services** under the outpatient **prescription** drug plan:

- You need a **prescription** (except for over-the-counter contraceptives approved by the FDA) from the prescribing **provider**
- You need to show your ID card to the network pharmacy when you get a **prescription** filled

This plan provides insurance coverage for many kinds of **covered services**, such as a **physician's** care and **hospital stays**, but some services aren't covered at all or are limited. For other services, the plan pays more of the expense.

For example:

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation.
- Your **provider** may recommend services that are considered **experimental** and **investigational** services. But an **experimental** and **investigational** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.
- Preventive services. Usually the plan pays more, and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below.

Some services require **precertification** from us. For more information see the *How your plan works – Medical necessity and precertification requirements* section.

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. You can find out about limitations for **covered services** in the schedule of benefits. If you have questions, contact us.

Acupuncture

Covered services include acupuncture services provided by a **physician** if the service is provided as a form of anesthesia in connection with a covered **surgical procedure**.

Covered services also include services performed to alleviate, treat, or limit:

- Chronic pain
- Postoperative and chemotherapy-induced nausea and vomiting
- Nausea during pregnancy
- Postoperative dental pain
- Temporomandibular disorders (TMD)
- Migraine headache
- Pain from osteoarthritis of the knee or hip

The following are not **covered services**:

- Acupressure

Ambulance services

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency

Covered services also include **precertified** transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital, skilled nursing facility** or acute rehabilitation **hospital,** an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not **covered services**:

- Non-emergency airplane transportation by an **out-of-network provider**
- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is the process of applying interventions based on principles of learning that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental** and **investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental and investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an "approved clinical trial" only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Dental care anesthesia

Covered services include anesthesia for dental care, that your **physician** has certified, cannot be performed in the dentist's office due to age or condition of the covered person.

The following are not **covered services**:

- The related dental service unless specifically listed as a covered service in this certificate.

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your plan only covers the same type of DME that Medicare covers but, there are some DME items Medicare covers that your plan does not. You or your **provider** can contact us to find out if a DME item is a **covered service** under your plan.

Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:

- One item of DME for the same or similar purpose
- Repairing DME due to normal wear and tear
- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. You can get **emergency services** from **network providers** or **out-of-network providers**.

If your **physician** decides you need to **stay** in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity and precertification requirements* section and this *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your **network physician** or **primary care physician** (**PCP**).

Non-emergency services

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for this information.

The following are not **covered services**:

- Non-emergency care in a **hospital** emergency room

Foot orthotic devices

Covered services include a mechanical device, ordered by your **physician**, to support or brace weak or ineffective joints or muscles of the foot.

Habilitation therapy services

Habilitation therapy services help you keep, learn or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services must be performed by a:

- Licensed or certified physical, occupational or speech therapist
- **Hospital, skilled nursing facility** or hospice facility
- **Home health care agency**
- **Physician**

Outpatient physical, occupational, and speech therapy

Covered services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (speech function is the ability to express thoughts, speak words and form sentences)

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Hearing aids

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

Covered services include prescribed hearing aids and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who:
    - Is legally qualified in audiology
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:

- Replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within a 36 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hearing exams

Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing **specialist**.

The following are not **covered services**:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

Home health care

Covered services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.

Physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See *Rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not **covered services**:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Home hemophilia treatment

Covered services include home treatment of bleeding disorders associated with hemophilia. The home treatment must be provided by a "designated" health care **provider**. A designated health care **provider** means a **provider** approved by the New Jersey Department of Banking and Insurance to contract with carriers for the purpose of rendering services for the home treatment of bleeding episodes associated with hemophilia.

Loss of Designated Status

When a designated health care **provider** loses their designation, we shall not continue to refer you to that health **provider.** If you have been using such a **provider,** we will continue to provide services at network level until:

- A new designated health care provider arrangement is made or
- Four months following the date of the loss of designation, whichever comes first

We shall not be required to continue to provide services at a network level when the **provider's** loss of designation is the result of:

- Revocation or surrender of a license, permit or registration
- Suspension of a license, permit or registration that cannot be corrected by reinstatement within 45 days following the date of the suspension, except as may be necessary for us and the **provider** to transition care to another designated health care provider

Termination of Agreement
If we or a designated health care **provider** terminates their agreement, we shall continue to provide services at a network level until:

- A new designated health care provider arrangement is made or
- Four months following the date of the loss of designation, whichever comes first

The requirements above shall not apply when the agreement terminates on the basis of:

- Breach
- Fraud

Hospice care

Covered services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite care

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an employee of the hospice care agency responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription** drugs
  - Psychological counseling
  - Dietary counseling

The following are not **covered services**:

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
  - Sitter or companion services for you or other family members
  - Transportation
  - Maintenance of the house

Hospital care

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition or when only private rooms are available.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.

The following are not **covered services**:

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Infertility services

Covered services include visiting a **provider**:

- To diagnose and evaluate the underlying medical cause of **infertility** including up to 12 intrauterine insemination (IUI) procedures for members without a partner as limited under the definition of infertility. **Covered services** are dependent on age and prior care received.
- To do **surgery** to treat cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- For ovulation induction cycle(s) while on oral synthetic ovulation stimulants and menotropin injectable medications to stimulate the ovaries
- For artificial insemination, which includes Intrauterine (IUI)/intracervical (ICI) insemination
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Oral and injectable synthetic ovulation stimulant **prescription** drugs used: primarily for
- To stimulate the ovaries
- Primarily for treating the underlying cause of **infertility**
- Once diagnosed as infertile we will cover expenses, including but not limited to following expenses:
- Assisted reproductive technology (ART), including medications.
- Surgery needed to treat the underlying medical cause of **infertility** including microsurgical sperm aspiration.

For help using the comprehensive **infertility** health care services you may enroll with our National **Infertility** Unit (NIU). To enroll you can reach our dedicated NIU at 1-800-575-5999.

You are eligible for **infertility** services if:

- You are covered under this plan. For the purposes of this provision, when we refer to your partner, we mean spouse, domestic partner or civil union partner.
- There exists a condition that:
  - Is demonstrated to cause the disease of **infertility**.
  - Has been recognized by your or your partner's **physician** or **infertility specialist** and documented in your or your partner's medical records.
  - You or your partner are unable to carry a pregnancy to live birth.
- You or your partner have not had a voluntary sterilization with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Or any procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health.
- You or your partner do not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- Medical necessity for ART procedures has been established.
  - The infertile member is 45 years of age or younger and has not reached the limit of 4 completed egg retrievals where the covered person's cost is covered by insurance plans or programs offered or administered by the contract holder through Aetna or an affiliated company. An infertile member over 45 years of age is not eligible for egg retrievals.
  - ART services include, but are not limited to:
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfers)
  - Intracytoplasmic sperm injection (ICSI) or ovum microsurgery
  - Assisted hatching (AH)
  - Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
  - Charges associated with obtaining the spouse's sperm for ART services, when the spouse is also covered under this plan.
  - You and your partner have met the requirement for the number of months trying to conceive:
  - You are a member under 35 years of age with a partner who has had 12 months or more of unprotected sexual intercourse.
  - You are a member under 35 years of age without a partner who has had 12 failed attempts of intrauterine insemination under medical supervision. The number of months of unprotected sexual intercourse does not apply.
  - You are a member 35 years of age or older with a partner who has had unprotected sexual intercourse 6 months or more.
  - You are a member 35 years of age or older without a partner who has had 6 failed attempts of intrauterine insemination under medical supervision.
  - If you have been diagnosed with premature ovarian insufficiency (POI), you are eligible for ART services through age 45 regardless of FSH level.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You are eligible for fertility preservation if you are covered under this plan and:

- Are believed to be fertile
- Have planned services that may cause **infertility** such as:
  - Chemotherapy
  - Pelvic radiotherapy
  - Other gonadotoxic therapies
  - Ovarian or testicular removal
- You are covered under this plan and have a diagnosis of latrogenic infertility caused by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.
- Or any procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health.
- You are covered under this plan and have a diagnosis of cancer and you are planning cancer treatment that is demonstrated to result in **infertility.** Planned cancer treatments include:
  - Bilateral orchiectomy (removal of both testicles).
  - Bilateral oophorectomy (removal of both ovaries).
  - Hysterectomy (removal of the uterus).
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**.
- The eggs that will be retrieved for use are likely to result in a successful pregnancy by meeting the criteria below:
  - You are a member under 35 years of age that has had an unmedicated day 3 FSH test done within the past 12 months. The results of your unmedicated day 3 FSH test must be less than 19mIU/mL in your most recent lab test to use your own eggs.
  - You are a member 35 years of age or older that has had an unmedicated day 3 FSH test done within the past 6 months. The results of your unmedicated day 3 FSH test must be less than 19mIU/mL in your most recent lab test to use your own eggs if you are less than age 40. If you are age 40 and older, the results of your unmedicated day 3 FSH test must be less than 19mIU/mL in all prior tests to use your own eggs.

Our NIU is here to help. It is staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help:

- Enroll in the **infertility** program.
- Assist with **precertification** of **covered services**.
- Coordinate **precertification** for ART services and fertility preservation services when these services are **covered services**. Your **provider** should obtain **precertification** for fertility preservation through the NIU either directly or through a reproductive endocrinologist.
- Evaluate medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.

A cycle is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered complete at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

The following are not **covered services**:

- Cryopreservation (freezing), storage of eggs, embryos, or sperm or reproductive tissue, unless due to iatrogenic infertility.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate where the surrogate is not covered under this plan. A surrogate is a member carrying their own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- More than four completed egg retrievals while you are covered under this plan or any other plan with this contract holder. Any egg retrievals cycles that were not covered by insurance do not count against the four completed egg retrieval limit.
- Egg retrievals if you are over 45 years of age.

Jaw joint disorder treatment

Covered services include the diagnosis of non-surgical and surgical treatment of **jaw joint disorder** by a **provider**, including:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

The following is not a **covered service:** non-surgical medical and dental services, and therapeutic services related to **jaw joint disorder**

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

We provide such coverage subject to the following:

- The attending **physician** prescribes inpatient care
- The mother must request the inpatient care

Covered services also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Mental health conditions

Mental health conditions treatment

Covered services include the treatment of **mental health conditions** provided by a **hospital, psychiatric hospital, residential treatment facility, physician,** or **behavioral health provider** including:

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition or when only private rooms are available), and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital,** or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital,** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** and/or **telehealth** consultation)
  - Individual, group, and family therapies for the treatment of **mental health conditions**
  - Other outpatient **mental health conditions** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for **mental health conditions** treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for **mental health conditions** treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Autism spectrum disorder or other developmental disabilities

Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

A developmental disability is a severe, chronic disability which:

- Is attributable to a mental or physical impairment or a combination of them
- Is likely to continue indefinitely;
- Limits function in at least three of the following:
  - Self-care
  - Language
  - Learning
  - Mobility
  - Self-direction
  - Independent living
  - Economic self-sufficiency
- Reflects the need for special care, treatment or other services which are lifelong or of extended duration.

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder or other developmental disability
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder or other developmental disability
- Applied Behavior Analysis (ABA)

Substance use disorders treatment

Covered services include the treatment of **substance use disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician**, or **behavioral health provider** as follows:

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition or when only private rooms are available), and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital**, or **residential treatment facility**. Treatment of **substance use disorders** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance use disorders** section or unit, unless you are admitted for the treatment of medical complications of **substance use disorders.** As used here, "medical complications" include, but are not limited to:
  - Electrolyte imbalances
  - Malnutrition
  - Cirrhosis of the liver
  - Delirium tremens
  - Hepatitis
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine and/or telehealth** consultation)
  - Individual, group, and family therapies for the treatment of **substance use disorders**

- Other outpatient **substance use disorders** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Nutritional support

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein. Also for the purposes of this benefit, "medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a **physician**.

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids. **Covered services** also include donated breast milk which may include milk fortifiers for infants.

The following are not **covered services**:

- Any food item, including:
    - Infant formulas
    - Nutritional supplements
    - Vitamins
    - Other nutritional items

Obesity surgery and services

Obesity **surgery** is a type of procedure performed on people who are morbidly obese for the purpose of losing weight. Your **physician** will determine whether you qualify for obesity **surgery**.

Covered services include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription** drugs included under the *Outpatient prescription drugs* section
- One obesity **surgical procedure**
- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not **covered services:**

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial surgery treatment (mouth, jaws and teeth)

Covered services include the following when provided by a **physician**, a dentist and **hospital**:

- Cutting out:
  - Cysts, tumors, or other diseased tissues.
- Cutting into gums and tissues of the mouth:
  - Only when not associated with the removal, replacement or repair of teeth

Outpatient surgery

Covered services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery** center or a **hospital's** outpatient department.

Important note:
Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician, PCP** services and not for a separate fee for facilities.

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Physician services

Covered services include services by your **physician** to treat an illness or injury. You can get services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine** and/or **telehealth**

Important note:
For treatment of **mental health conditions**, all in-person, **covered services** with a **behavioral health provider** are also **covered services,** if you use **telemedicine** and/or **telehealth** instead.

Telemedicine and/or **telehealth** may have a different cost share from other **physician** services. See your schedule of benefits.

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Prescription drugs - outpatient

Read this section carefully. This plan does not cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription** drug benefits, including limits, see the schedule of benefits.

Important note:
A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's FDA-approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered services are based on the drugs listed in the **drug guide**. **Prescription drugs** listed on the **formulary exclusions list** are excluded from preferred cost-sharing unless we approve a medical exception prior to the drug being picked up at the pharmacy. If it is **medically necessary** for you to use a **prescription** drug that is not in this **drug guide**, you or your **provider** must request a medical exception. See *the Precertification section* or just contact us.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a pharmacy
- Calling or e-mailing a **prescription** to a pharmacy
- Submitting the **prescription** to a pharmacy electronically

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy can coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription** drugs.

How to access network pharmacies

You can find a network pharmacy either online or by phone. See the *Contact us* section for how.

You may go to any of our network pharmacies. Pharmacies include network **retail, mail order** and **specialty pharmacies**.

Some **prescription** drugs are subject to quantity limits. This helps your **provider** and pharmacy ensure your **prescription** drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a **generic drug** when it is available.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of **prescription** drugs. A network **retail pharmacy** will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit.

Mail order pharmacy
The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each **prescription** and refill is limited to a maximum 90 day supply.

Prescription refills after the initial fill can be filled at a network **mail order pharmacy**.

Specialty pharmacy
We cover **specialty prescription drugs** when filled through a network **retail** or **specialty pharmacy**.
Each **prescription** is limited to a maximum 90 day supply. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by us, your **provider**, and/or your network pharmacy. The outcome of this review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

How to access out-of-network pharmacies

You can directly access an out-of-network pharmacy to get covered outpatient **prescription drugs.**
When you use an out-of-network pharmacy, you pay your in-network **copayment** or **coinsurance** then you pay any remaining **deductible** and then you pay your out-of-network **coinsurance**. If you use an out-of-network pharmacy to obtain outpatient **prescription drugs**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your in-network outpatient **prescription drug** cost share
- Paying your out-of-network outpatient **prescription drug deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims

How to get an emergency prescription filled

You may not have access to a network pharmacy in an emergency or urgent situation or you may be traveling outside of your plan's service area. If you must fill a **prescription** in any of these situations, we will reimburse you as shown in the table below:

Type of pharmacy	Your cost share is
A network pharmacy	The plan cost share
Out-of-network pharmacy	The full cost of the **prescription**

When you pay the full cost of the **prescription** at an out-of-network pharmacy:

- You will fill out and send a **prescription** drug refund form to us, including all itemized pharmacy receipts
- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation
- Submission of the refund form doesn't guarantee a refund. If approved, you will be reimbursed the cost of the **prescription** less your network cost share

Other covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs
Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Contraceptives (birth control)
For females who are able to become pregnant, **covered services** include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies
Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the *Diabetic services, supplies, equipment, and self-care programs* section for medical **covered services**.

Immunizations
Covered services include preventive immunizations as required by the ACA when given by a network pharmacy. You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Infertility drugs
Covered services include synthetic ovulation stimulant **prescription** drugs used to treat the underlying medical cause of **infertility**.

OTC drugs
Covered services include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging on to the Aetna website.

Preventive care drugs and supplements
Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA.

Risk reducing breast cancer prescription drugs
Covered services include **prescription** drugs used to treat people who are at:

- Increased risk for breast cancer
- Low risk for medication side effects

Sexual enhancement or dysfunction prescription drugs
Covered services include prescription drugs for the treatment of sexual enhancement or dysfunction.
For the most up-to-date information on covered **prescription** drugs and doses, contact us.

Tobacco cessation prescription and OTC drugs
Covered services include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the pharmacy for processing.

The following are not **covered services**:

- Abortion drugs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Drugs or medications
  - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
  - That include the same active ingredient or a modified version of an active ingredient as a covered **prescription** drug unless we approve a medical exception
  - That is therapeutically the same or an alternative to an OTC drug unless we have approved a medical exception
  - Not approved by the FDA (except those provided under the Anti-cancer drugs taken by mouth, including chemotherapy drugs provision) or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire due to relationship distress or other stressors, the effects of substance or medication, or the effects of another medication condition, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
  - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications unless such change in weight is due to the effects of substance or medication, or the effects of another medication condition.
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies

- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs
  - Needles and syringes except for those used for insulin administration

- Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment to a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When updated, they will apply to this plan. The updates are effective on the first day of the year, one year after the updated recommendation or guideline is issued.

For frequencies and limits, contact your **physician** or us. This information is also available at https://www.healthcare.gov/.

Important note:
Gender-specific preventive care benefits include **covered services** described regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

Breast-feeding support and counseling services

Covered services include assistance and training in breast-feeding and counseling services during pregnancy or at any time after delivery. Your plan will cover this counseling only when you get it from a certified breast-feeding support **provider**.

Breast pump, accessories and supplies

Covered services include renting or buying equipment you need to pump and store breast milk.

Coverage for the purchase of breast pump equipment is limited to two breast pump kits per birth. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Counseling services

Covered services include preventive screening and counseling by your **health professional** for:

- **Substance use disorders**
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
  - Tobacco cessation
    - Preventive counseling to help stop using tobacco products
    - Treatment visits
    - Class visits
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
  - Preventive counseling and risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection

Family planning services – contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are provided, administered, or removed by a **physician** during an office visit.
- Voluntary sterilization including charges billed separately by the **provider** for voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

The following are not preventive **covered services**:

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA

Immunizations

Covered services include preventive immunizations for infectious diseases.

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician**, **PCP**, OB, GYN or OB/GYN office. The exams include initial and subsequent visits for:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening
- Maternal weight
- Rh incompatibility screening

Contraceptives (birth control)
For females who are able to become pregnant, **covered services** include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from you **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception methods is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost to you. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** or devices for that method at no cost.

After an initial 3 month supply is dispensed, a 6 month supply of the same contraceptive is covered regardless of whether the initial **prescription** was covered under the plan. For specific cost sharing see your **schedule** of benefits *Outpatient **prescription drugs*** or *Family planning services - contraceptives* section.

Important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive care are not medically appropriate for you. Your **provider** may request a medical exception and submit the exception to us for review.

Routine cancer screenings
Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams
A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup
- For covered newborns:
  - An initial **hospital** checkup
  - Hearing loss screenings include periodic monitoring for delayed onset hearing loss

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a **physician**, **PCP**, OB, GYN or OB/GYN for services including Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Private duty nursing - outpatient

Covered services include private duty nursing care, ordered by a **physician** and provided by an R.N. or L.P.N. provided in the home when:

- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

You may receive a prosthetic device as part of another **covered service** and therefore it will not be covered under this benefit.

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses
- The following coverage is provided following a mastectomy
  - A minimum of 72 hours of inpatient care following a modified radical mastectomy
  - A minimum of 48 hours of inpatient care following a simple mastectomy
  - A shorter length of stay, if you in consultation with the physician determine a shorter length of stay is medically necessary

Reconstructive surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Covered services also include the procedures or **surgery** to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Covered services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility** or **physician's** office, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Covered services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if they are part of a treatment plan ordered by your **physician**. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a **hospital, skilled nursing facility**, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- **Hospital, skilled nursing facility**, or hospice facility
- **Home health care agency**
- **Physician**

Covered services include spinal manipulation to correct a muscular or skeletal problem. Your **provider** must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
  - Improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
  - Help you relearn skills so you can improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**
  - Improve delays in speech function development caused by a gross anatomical defect present at birth (speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Sickle cell anemia

Covered services include the medical expenses and **prescription** drugs for treatment of sickle cell anemia

Skilled nursing facility

Covered services include **precertified** inpatient **skilled nursing facility** care. This includes:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies provided during a **stay** in a **skilled nursing facility**

Tests, images and labs

Diagnostic complex imaging services

Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

These are covered only when you get them from a licensed radiology **provider** or lab.

Diagnostic x-ray and other radiological services

Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology **provider**. See *Diagnostic complex imaging services* above for more information.

Therapies – chemotherapy, infusion, radiation

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. **Covered services** include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a **hospital**
- A **physician's** office
- Your home from a home care **provider**

You can access the list of preferred infusion locations by contacting us.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Certain infused medications may be covered under the outpatient **prescription** drug benefit. You can access the list of **specialty prescription drugs** by contacting us.

Radiation therapy

Covered services include the following radiology services provided by a **health professional**:

- Accelerated particles
- Gamma ray
- Mesons
- Neutrons
- Radioactive isotopes
- Radiological services
- Radium

Transplant services

Covered services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

Covered services also include:

- Travel and lodging expenses
  - If you are working with an Institutes of Excellence™ (IOE) facility that is 100 or more miles away from where you live, travel and lodging expenses are **covered services** for you and a companion, to travel between home and the IOE facility
  - Coach class air fare, train or bus travel are examples of **covered services**

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as Institutes of Excellence™ (IOE) facilities in your **provider** directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment, coinsurance, deductible, maximum out-of-pocket** and limits, unless stated differently in this certificate and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment, coinsurance, deductible, maximum out-of-pocket**, and limits, unless stated differently in this certificate and schedule of benefits.

Important note:
If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs.. If you don't get your transplant services at the IOE facility we designate, your cost share will be higher.

Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

The following are not **covered services**:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Urgent care services

Covered services include services and supplies to treat an **urgent condition** at an urgent care center. An "urgent care center" is a facility licensed as a freestanding medical facility to treat **urgent conditions**. **Urgent conditions** need prompt medical attention but are not life-threatening.

If you need care for an **urgent condition**, you should first seek care through your **physician, PCP**. If your **physician, PCP** is not reasonably available to provide services, you may access urgent care from an urgent care facility.

If you go to an urgent care center for what is not an **urgent condition**, the plan may not cover your expenses. See the schedule of benefits for more information.

Covered services include services and supplies to treat an **urgent condition** at an urgent care center as described below:

- **Urgent condition** within the network (in-network)
  - If you need care for an **urgent condition**, you should first seek care through your **physician, PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center that is in-network.
- **Urgent condition** outside the network (out-of-network)
  - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and getting the health care service cannot be delayed.

Vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Walk-in clinic

Covered services include, but are not limited to, health care services provided at a **walk-in clinic** for:

- Scheduled and unscheduled visits for illnesses and injuries that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license

General plan exclusions

The following are not **covered services** under your plan:

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the *Coverage and exclusions*, *Transplant services* section

Important note:
This exception does not apply to services provided in the *Home hemophilia treatment* section.

Cosmetic services and plastic surgery

Any treatment, **surgery** (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, except where described in *Coverage and exclusions* under the *Reconstructive breast surgery and supplies* and *Reconstructive surgery and supplies* sections

Cost share waived

Any cost for a service when any **out-of-network provider** waives all or part of your **copayment**, **coinsurance**, **deductible**, or any other amount

Court-ordered services and supplies

This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a **covered service** under your plan

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan. Call the number on your ID card if you have any questions.
- Dental implants

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

Experimental and investigational

Experimental and investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trials.

Foot care

Routine services and supplies for the following:

- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth

Maintenance care

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services

Medical supplies – outpatient disposable

Any outpatient disposable supply or device. Examples of these include:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Home test kits not related to diabetic testing
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Mental health conditions and substance use disorders conditions treatment

The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates **mental health conditions** treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Missed appointments

Any cost resulting from a canceled or missed appointment

Nutritional support

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- **Prescription** vitamins
- Other nutritional items

Other non-covered services

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan

Other primary payer

Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

Any service or supply primarily for your convenience and personal comfort or that of a third party

Prescription or non-prescription drugs and medicines - outpatient

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by the policyholder or through a third party vendor contract with the policyholder

Routine exams

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Covered services and exclusions* section

Services provided by a family member

Services provided by a spouse, civil union partner, domestic partner, parent, child, stepchild, brother, sister, in-law, or any household member

Services, supplies and drugs received outside of the United States

Non-emergency medical services, outpatient **prescription** drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate.

Sexual dysfunction and enhancement due to a physical condition

Any treatment, **prescription** drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire due to relationship distress or other stressors, the effects of substance or medication, or the effects of another medication condition, including:

- **Surgery**, **prescription** drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Telemedicine and/or telehealth

- Services given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Treatment in a federal, state, or governmental entity

Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

Important note:
A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

How your plan works

How your medical plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services

Your cost share is lower when you use a **network provider**.

Providers

Our **provider** network is there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider** directory. Just log in to the Aetna website.

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**. Your plan may pay a bigger share for **covered services** you get through your **PCP**, so choose a **PCP** as soon as you can.

Service area

Your plan generally pays for **covered services** only within a specific geographic area, called a service area. There are some exceptions, such as for **emergency services**, urgent care, and transplant services.
See the *Who provides the care* section below.

How your medical plan works while you are covered out-of-network

With your out-of-network coverage:

- You can get care from **providers** who are not part of the Aetna network
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **precertification**
- Your cost share will be higher

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already an Aetna member and your **provider** stops being in our network

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details. If we approve your request to keep going to your current **provider**, we will tell you how long you can continue to see the **provider**. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

We will authorize coverage only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

Who provides the care

Network providers

We have contracted with **providers** in the service area to provide **covered services** to you. These **providers** make up the network for your plan.

To get network benefits, you must use **network providers**. There are some exceptions:

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

You may select a **network provider** from the online directory through your member website.

You will not have to submit claims for services received from **network providers**. Your **network provider** will take care of that for you. And we will pay the **network provider** directly for what the plan owes.

Your PCP

We encourage you to get **covered services** through a **PCP**. They will provide you with primary care.

How you choose your PCP

You can choose a **PCP** from the list of **PCPs** in our directory.

Each covered family member is encouraged to select a **PCP**. You may each choose a different **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What your PCP will do for you

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Changing your PCP

You may change your **PCP** at any time by contacting us.

Medical necessity and precertification requirements

Your plan pays for its share of the expense for **covered services** only if the general requirements are met. They are:

- The service is **medically necessary**
- For in-network benefits, you get the service from a **network provider**
- You or your **provider precertifies** the service when required

Medically necessary, medical necessity

The **medical necessity** requirements are in the *Glossary* section, where we define "**medically necessary, medical necessity**." That is where we also explain what our medical directors or a **physician** they assign consider when determining if a service is **medically necessary**.

Important note:
We cover **medically necessary**, sex-specific **covered services** regardless of identified gender.

Precertification

Read this provision carefully to learn how to avoid possible benefit reductions

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**.

In-network

Your network **physician** is responsible for obtaining any necessary **precertification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **precertification**. But if your **physician** requests **precertification** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Out-of-network

When you go to an **out-of-network provider**, you are responsible to get any required **precertification** from us. If you don't **precertify**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit,** if you have any.

Timeframes for **precertification** are listed below. For **emergency services, precertification** is not required, but you should notify us as shown. **Precertification** is not required for **substance use disorder** treatment for the first 180 days of treatment.

To obtain **precertification**, contact us. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled

An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your **physician** in writing of the **precertification** decision. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **precertified**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your **physician** in writing of an approval or denial of the extra days.

If you or your **provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require precertification
Precertification is required for inpatient **stays** and certain outpatient services and supplies
Precertification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Stays in a **hospital**	Applied behavior analysis
Stays in a hospital for treatment of **substance use disorder** beginning on the 28th of the plan year whether the days are consecutive or intermittent partial days or full days	
Stays in a **skilled nursing facility**	Complex imaging
Stays in a **rehabilitation facility**	Comprehensive **infertility** services and ART services
Stays in a **hospice** facility	**Cosmetic** and reconstructive **surgery**
Stays in a **residential treatment facility** for treatment of **mental health conditions**	Emergency transportation by airplane
Stays in a **residential treatment facility** for treatment of **substance use disorder** beginning on the 181st day of the plan year whether the days are consecutive or intermittent partial days or full days	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
Obesity **surgery** (bariatric)	Kidney dialysis
	Outpatient back **surgery** not performed in a **physician's** office
	Private duty nursing services
	Sleep studies
	Knee **surgery**
	Wrist **surgery**
	Transcranial magnetic stimulation (TMS)
	Psychological testing/neuropsychological testing
	Intensive outpatient program (IOP) – mental health condition
	Intensive outpatient program (IOP) – substance use disorders diagnoses beginning on the 181st day of the plan year whether the days are consecutive or intermittent, partial days or full days
	Partial hospitalization treatment – **substance use disorders** diagnoses beginning on the 181st day of the plan year whether the days are consecutive or intermittent, partial days or full days

Contact us to get a list of the services that require **precertification**. The list may change from time to time.

Sometimes you or your **provider** may want us to review a service that doesn't require **precertification** before you get care. This is called a predetermination, and it is different from **precertification.** Predetermination means that you or your **provider** requests the pre-service clinical review of a service that does not require **precertification**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Certain **prescription** drugs are covered under the medical plan when they are given to you by your **physician** or health care facility. The following **precertification** information applies to these **prescription** drugs:

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

Contact us or go online to get the most up-to-date **precertification** requirements.

Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

You, someone who represents you or your **provider** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation. For directions on how you can submit a request for a review:

- Call the toll-free number on your ID card
- Log in to the Aetna website at https://www.aetna.com/
- Submit the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road, Richardson, TX 75081

You, someone who represents you or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

What the plan pays and what you pay

Who pays for your **covered services** – this plan, both of us, or just you? That depends.

The general rule

The schedule of benefits lists what you pay for each type of **covered service**. In general, this is how your benefit works:

- You pay the **deductible**, when it applies.
- Then the plan and you share the expense. Your share is called a **copayment** or **coinsurance**.
- Then the plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**, and **allowable amount** for an **out-of-network provider**.

Negotiated charge

For health coverage:

This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

Some **providers** are part of Aetna's **network** for some Aetna plans but are not considered **network providers** for your plan. For those **providers**, the **negotiated charge** is the amount that **provider** has agreed to accept for rendering services or providing **prescription** drugs to members of your plan.

We may enter into arrangements with **network providers** or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

These arrangements will not change the **negotiated charge** under this plan.

*For **prescription** drug services:*

When you get a **prescription** drug, we have agreed to this amount for the **prescription** or paid this amount to the network pharmacy or third party vendor that provided it. The **negotiated charge** may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.

Allowable amount

This is the amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area where you get the service or supply. **Allowable amount** doesn't apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an **out-of-network provider**
- Not available from a **network provider**
- An **emergency service**

The table below shows the method for calculating the **allowable amount** for specific services or supplies:

Service or supply:	**Allowable amount is based on:**
Professional services and other services or supplies not mentioned below	Reasonable amount rate
Services of **hospitals** and other facilities	Reasonable amount rate
Prescription drugs	110% of average wholesale price (AWP)

Important note:
See *Special terms* used, below, for a description of what the **allowable amount** is based on.
If the **provider** bills less than the amount calculated using a method above, the **allowable amount** is what the **provider** bills.

If your ID card displays the National Advantage Program (NAP) logo, your cost share may be lower when you get care from a NAP **provider**. These are **out-of-network providers** and third party vendors who have contracts with us but are not **network providers**. When you get care from a NAP **provider**, your out-of-network cost share applies.

Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a **prescription** drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific **provider** performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
  - The method CMS uses to set Medicare rates
  - How much other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable

  We may make the following exceptions:
  - For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
  - Our rate may exclude other payments that CMS may make directly to **hospitals** or other **providers** and backdated adjustments
  - For anesthesia, our rate may be at least 100% of the rate CMS establishes
  - For lab, our rate may be 75% of the rate CMS establishes
  - For DME, our rate may be 75% of the rate CMS establishes

  For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes.

  When the **allowable amount** is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to **providers** under Medicare programs.

- Reasonable amount rate means your plan has established a rate amount as follows:

Service or supply:	**Reasonable amount rate is:**
Professional services	80th percentile value reported in a database prepared by FAIR Health
Inpatient and outpatient **hospital** charges	175% Medicare allowed rate
Inpatient and outpatient charges that are not from a **hospital**	175% Medicare allowed rate

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the **allowable amount**. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

Get the most from your benefits:
We have online tools to help you decide whether to get care and if so, where. Use the 'Estimate the Cost of Care' tool or 'Payment Estimator' tool on the Aetna website. The website may contain additional information that can help you determine the cost of a service or supply.

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. For in-**network** coverage, they are:

- The service is **medically necessary**
- You get your care from a **network provider**
- You or your **provider precertifies** the service when required

For **out-of-network** coverage:

- The service is **medically necessary**
- You get your care from an **out-of-network provider**
- You or your **provider precertifies** the service when required

For outpatient **prescription** drugs, your costs are based on:

- The type of **prescription** you're prescribed
- Where you fill the **prescription**

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

Generally, your plan and you share the cost for **covered services** when you meet the general requirements. But sometimes your plan will pay the entire expense, and sometimes you will. For details, see your schedule of benefits and the information below.

You pay the entire expense when:

- You get services or supplies that are not **medically necessary**.
- Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care from an **out of-network provider** and the **provider** waives all or part of your cost share.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your **deductible** or your **maximum out-of-pocket limit**.

Where your schedule of benefits fits in

The schedule of benefits shows any out-of-pocket costs you are responsible for when you receive **covered services** and any benefit limitations that apply to your plan. It also shows any **maximum out-of-pocket limits** that apply.

Limitations include things like maximum age, visits, days, hours, and admissions. Out-of-pocket costs include things like **deductibles, copayments** and **coinsurance**.

Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB).

Key Terms

Here are some key terms we use in this section. These will help you understand this COB section.

Allowable expense means:

- The charge for any health care service, supply or other expense for which you are responsible when the health care service, supply or other expense is covered at least in part by any of the plans involved, except where a law requires another definition, or as stated below.

  When this plan is coordinating benefits with a plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, allowable expense is limited to items covered under the other plan.

  We will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an allowable expense unless the stay in a private room is medically necessary and appropriate.

  When this plan is coordinating benefits with a plan that limits coordination of benefits to a specific coverage, we will only consider corresponding services, supplies or other expense which the other plan considers an allowable expense.

Claim determination period means:

- A calendar year, or any part of a calendar year, during which you and/or your dependents are covered by this plan and at least one other plan and incurs allowable expense(s) under these plans.

Plan means:

- Coverage with which coordination of benefits is allowed. Plan includes:
  - Group insurance and group subscriber contracts, including insurance continued according to a federal or state continuation law
  - Self-funded arrangements of group or group-type coverage, including insurance continued according to a federal or state continuation law
  - Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued according to a federal or state continuation law
  - Group hospital indemnity benefit amounts that exceed $150.00 per day
  - Medicare or other governmental benefits, except when, according to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan

- Plan does not include:
  - Individual or family insurance contracts or subscriber contracts
  - Individual or family coverage through a health maintenance organization (HMO) or under any other prepayment, group practice and individual practice plans
  - Group or group-type coverage where the cost of coverage is paid solely by the covered person Coverage being continued according to a federal or state continuation law will be considered a plan
  - Group hospital indemnity benefit amounts of $150.00 per day or less
  - School accident-type coverage
  - A state plan under Medicaid

Primary plan means:

- A plan whose benefits for your health care coverage must be determined without taking into consideration the existence of any other plan. There may be more than one primary plan. A plan will be the primary plan if either of the below exist:
  - The plan has no order of benefit determination rules, or it has rules that differ from those contained in this coordination of benefits section, or
  - All plans which cover you use order of benefit determination rules consistent with those contained in the coordination of benefits section and under those rules, the plan determines its benefits first.

Reasonable and customary means:

- An amount that is not more than the usual or customary charge for the service or supply as determined by us, based on a standard which most often charged for a given service by a provider within the same geographic area

Secondary plan means:

- A plan which is not a primary plan. If you are covered by more than one secondary plan, the order of benefit determination rules of this coordination of benefits section will be used to determine the order in which the benefits payable under the multiple secondary plans are paid.
  The benefits of each secondary plan may consider:
  - The benefits of the primary plan(s) and
  - The benefits of any other plan which, under this coordination of benefits section, has its benefits determined before those of that secondary plan

How COB works

- We consider each plan separately when coordinating payments. The primary plan pays or provides services or supplies first, as though the secondary plan does not exist. If a plan has no COB provision, or if the order of benefit determination rules differ from those in this section, it is the primary plan. A secondary plan takes into consideration the benefits provided by a primary plan when, according to the rules below, the plan is the secondary plan. If there is more than one secondary plan, the order of benefit determination rules determine the order among the secondary plans. During each claim determination period the secondary plan(s) will pay up to the remaining unpaid allowable expenses, but no secondary plan will pay more than it would have paid if it had been the primary plan. The method the secondary plan uses to determine the amount to pay is outlined below in the *Determining who pays under a health plan* section.
- The secondary plan will not reduce allowable expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Determining who pays under a health plan

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary Plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	• Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How are benefits paid?

In order to determine which procedure to follow, it is necessary to consider:

- How the primary plan and the secondary plan pay benefits
- Whether the provider who provides or arranges the services and supplies is in the network of either the primary plan or the secondary plan.

Benefits may be based on the reasonable and customary charge (R & C), or some similar term. This means that the **provider** bills a charge and you may be responsible for the full amount of the billed charge. In this section, a plan that bases benefits on a reasonable and customary charge is called an R & C plan.

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a **provider**, called a **network provider**, bills a charge, you may be responsible only for an amount up to the negotiated fee. In this section, a plan that bases benefits on a negotiated fee schedule is called a fee schedule plan. If you use the services of a non-network **provider**, the plan will be treated as an R & C plan even though the plan under which you are covered calls for a fee schedule.

Payment to the **provider** may be based on a capitation. This means that the HMO or other plan pays the **provider** a fixed amount per covered person. You are responsible only for the applicable **deductible, coinsurance** or **copayment**. If you use the services of a non-network **provider**, the HMO or other plan will only pay benefits in the event of **emergency services** or urgent care. In this section, a plan that pays **providers** based upon capitation is called a capitation plan. In the rules below, **provider** refers to the **provider** who provides or arranges the services or supplies and HMO refers to a health maintenance organization plan.

A plan determined to be a secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. Where a benefit is payable by both the primary and secondary plans on the basis of usual, customary and reasonable fees (UCR), the secondary plan will pay the difference between billed charges for allowable expenses and the amount paid by the primary plan as long as the amount is no greater than the amount the secondary plan would have paid if primary. The amount by which the secondary plan's benefits have been reduced will be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by you. As each claims is submitted the secondary plan will determine its obligation to pay for allowable expenses based on all claims which were submitted up to that time during the claim determination period.

The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision, and the benefits that would be payable for the allowable expenses under other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In this case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit will be reduced in proportion, and the amount paid will then be charged against any applicable benefit limit of this plan.

Primary plan is R & C plan and secondary plan is R & C plan

The secondary plan will pay the lessor of:

- The difference between the amount of the billed charges and the amount paid by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

When the benefits of the secondary plan are reduces as a result of this calculation, each benefit will be reduced in proportion, and the amount paid will be charged against any applicable benefit limit of the plan.

Primary plan is fee schedule plan and secondary plan is fee schedule plan
If the **provider** is a **network provider** in both the primary plan and the secondary plan, the allowable expense will be the fee schedule of the primary plan. The secondary plan will pay the lessor or

- The amount of any **deductible, coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

The total amount the **provider** receives from the primary plan, the secondary plan and you will not exceed the fee schedule of the primary plan. In no event will you be responsible for any payment in excess of the **copayment, coinsurance** or **deductible** of the secondary plan.

Primary plan is R & C plan and secondary plan is fee schedule plan
If the **provider** is a **network provider** in the secondary plan, the secondary plan will pay the lesser of:

- The difference between the amount of the billed charges for the allowable expenses and the amount paid by the primary plan' or
- The amount the secondary plan would have paid if it had been the primary plan.

You will only be responsible for the **copayment, deductible** or **coinsurance** under the secondary plan if you have no responsibility for **copayment, deductible** or **coinsurance** under the primary plan and the total payments by both the primary and secondary plans are less than the **provider's** billed charges. In no event will you be responsible for any payment in excess of the **copayment, coinsurance** or **deductible** of the secondary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan
If the **provider** is a **network provider** in the primary plan, the allowable expense considered by the secondary plan will be the fee schedule of the primary plan. The secondary plan will pay the lesser of:

- The amount of any **deductible, coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan or fee schedule plan
If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, the secondary plan will pay benefits as if it were the primary plan.

Primary plan is capitation plan or fee schedule plan or R & C plan and secondary plan is capitation plan
If you receive services or supplies from a **provider** who is in the network of the secondary plan, the secondary plan will be responsible to pay the capitation to the **provider** and will not be responsible to pay the **deductible, coinsurance** or **copayment** imposed by the primary plan. You will not be responsible to pay any **deductible, coinsurance** or **copayments** of either the primary plan or the secondary plan.

Primary plan is an HMO and secondary plan is an HMO
If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, but the **provider** is in the network of the secondary plan, the secondary plan will pay benefits as if it were the secondary plan, except that the primary plan will pay out-of-network services, if any, authorized by the primary plan.

How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible but not covered, and Medicare would be your primary payer, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it. You are also eligible for Medicare even if you are not covered or if you refused it, dropped it, or didn't make a request for it.

How this plan works with automobile plans for automobile related injuries

This section explains how the benefits under this plan interact with benefits available when expenses are incurred as a result of an automobile related injury.

Key terms

Automobile related **injury** means:

- Bodily **injury** sustained by a person as a result of an accident:
  - while occupying, entering, leaving or using an automobile; or
  - as a pedestrian

  caused by an automobile or an object propelled by or from an automobile.

Allowable expense means:

- A **medically necessary**, reasonable and customary item of expense covered at least in part as an eligible expense by:
  - The policy
  - PIP, or
  - OSAIC

Eligible expense means:
That portion of medical expense incurred for treatment of an **injury** which is covered under this plan without application of cash **deductibles** and **copayments**, if any or **coinsurance**.

Out-of-State Automobile Insurance Coverage (OSAIC) means:

- Any coverage for medical expenses under an automobile insurance policy other than PIP.

OSAIC includes automobile insurance policies issued in another state or jurisdiction.

PIP means:

- Personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determining who pays when there is an automobile plan for automobile related injuries
This plan provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for you under this plan. This election is made by the named insurance under a PIP policy. Such election affects that person's family members who are not themselves named insured's under another automobile policy. This plan may be primary for one covered person, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

This plan is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to this plan. In that case this plan will be primary.

If there is a dispute as to which plan is primary, this plan will pay benefits as if it were primary.

If this plan is primary to PIP or OSAIC, it will pay benefits for **covered services** in accordance with its terms.

The rules of the coordination of benefits section of this plan will apply if:

- You are insured under more than one insurance plan, and
- Such insurance plans are primary to automobile insurance coverage.

If this plan is secondary to PIP or OSAIC, the actual benefits payable will be the lesser of:

- The allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying cash **deductibles** and **copayments,** or
- The benefits that would have been paid if this plan had been primary.

If this plan supplements coverage under Medicare, it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan.

Your plan must be offered through the policyholder.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Our rights

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a **provider** or another health plan, if we paid more than we should have paid

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *How your plan works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the **provider** treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 24 hours.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 15 days.

Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments, coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Filing a claim

When you see a **network provider**, that office will send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you see an out-of-network provider outside of New Jersey and receive the bill directly, you should send it to us as soon as possible with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and appeal procedures* section for that information.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

Claim decisions and appeal procedures

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in *Benefit payments and claims* in the *How your plan works* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an "adverse benefit determination" or "adverse decision." For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will answer urgent utilization review claim appeals within 36 hours for level one and two appeals and within 72 hours for an initial determination. We will answer utilization review pre-service claims within 15 calendar days. We will answer utilization review pre-service claim appeals within 10 calendar days for level one appeals and within 15 calendar days for level two appeals. There are no extensions for urgent care utilization review claims. Extensions for pre-service claim utilization are 15 days. The additional information request timeframe for urgent care utilization review claims is 72 hours. The additional information request timeframe for pre-service claim utilization review is 15 days. Responses to additional information requests are required within 48 hours for urgent care utilization claims and within 45 days for pre-service utilization claims.

A concurrent claim appeal will be addressed according to what type of service and claim it involves. We will answer urgent concurrent care claims within 24 hours if received at least 24 hours before the previously approved health care services end. Non-urgent concurrent care utilization claim review timeframes are 15 calendar days.

Any other claim appeal
You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

Extensions for non-utilization review post service claims are 15 calendar days. The additional information request and response timeframes for non-utilization review post service claims are 30 calendar days.

Benefit determination for level one and level two appeals depends on the response time from receipt of appeals. The timeframe for non-utilization claim review for rescission of coverage is 30 calendar days for both level one and level two appeals. Post service non-utilization claim timeframes for both level one and level two appeals are 30 calendar days.

If coverage is rescinded:

- We will provide you with a 30 day advance written notice prior to the date of the rescission
- We will refund any premiums paid for any period after the termination date, minus the cost of covered benefits provided during this period

The date of the rescission will be the date coverage would have otherwise terminated if a complaint had not been filed.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

Appeals of inpatient substance use disorder claims

Aetna will notify you, an authorized representative and your physician of an inpatient **substance use disorders** treatment claim decision within 24 hours. This notice will include your rights with regard to filing an expedited internal appeal of an adverse determination. **Aetna** will communicate the determination regarding your appeal of the adverse determination within 24 hours to you, an authorized representative and your **physician.**

If the determination is to uphold the denial, you, an authorized representative or your **physician** have the right to file an expedited external appeal with the Independent Health Care Appeals Program through the Department of Banking and Insurance. An independent utilization review organization shall make a determination within 24 hours.

If the independent utilization review organization upholds the determination and it is determined continued inpatient care is not medically necessary, **Aetna** shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and you shall only be responsible for any applicable **copayment, deductible** and **coinsurance** for the **stay** through that date as applicable under the contract. For any costs incurred after the day following the date of determination until the day of discharge, you shall only be responsible for any applicable cost sharing, and any additional charges shall be paid by the facility or **provider**.

Exhaustion of appeal process

In most situations, you must complete the two levels of appeal with us before you can take these other actions:

- Contact the New Jersey Department of Banking and Insurance to request an investigation of a claim, complaint or appeal:
  Department of Banking and Insurance
  Consumer Protection Services
  Office of Managed Care
  PO Box 329
  Trenton, New Jersey 08625-0329
  (888) 393-1062

- File a complaint or appeal with the New Jersey Department of Banking and Insurance
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the New Jersey Department of Banking and Insurance. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

External review

External review is a review done by people in an organization outside of Aetna. This is called an Independent Utilization Review Organization (IURO). An IURO is assigned by the State Insurance Commissioner and is made up of physicians or other appropriate providers. The IURO must have expertise in the problem or question involved.

You have a right to external review only if all the following conditions are met:

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental** and **investigational**

There are times when you do not have to complete the level one and level two appeals processes. You may pursue an appeal directly through the Independent Health Care Appeals program if:

- A determination on any appeal regarding urgent or emergency care is not given to you within 72 hours of receipt by us
- A determination on an initial appeal, is not given to you within 10 calendar days of the date we received the notice
- A determination of a subsequent level of appeals is not given to you within 20 business days of the date we received notice

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the request for external review form at the final adverse determination level.

You must submit the request for external review form:

- Department of Banking and Insurance
  Consumer Protection Services
  Office of Managed Care
  PO Box 329
  Trenton, New Jersey 08625-0329
  (888) 393-1062
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

You will pay for any information that you send and want reviewed by the IURO. The filing fee is $25.00 and will not exceed $75.00 annually per covered person. We will pay for information we send to the IURO plus the cost of the review.

The New Jersey Department of Banking and Insurance will contact the IURO that will conduct the review of your claim

The IURO will:

- Perform a preliminary review and immediately notify the covered person and/or provider in writing as to whether the appeal is accepted for processing
- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the IURO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IURO decision?

We will give you the IURO decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a request for external review form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse benefit determinations

- Your **provider** tells us a delay in receiving health care services would:
  - Jeopardize your life, health or ability to regain maximum function
  - Be much less effective if not started right away (in the case of **experimental** and **investigational** treatment)

For final adverse determinations

Your **provider** tells us a delay in receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental** and **investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 48 hours of us getting your request.

Utilization review

Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal except those described in the *External review* provision.

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

The policyholder decides and tells us who is eligible for health coverage.

When you can join the plan

You can enroll:

- At the end of any waiting period the policyholder requires
- Once each year during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

You can enroll eligible family members (these are your "dependents") at this time too.

If you don't enroll when you first quality for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your civil union partner who meets any policyholder rules and requirements under state law
- Your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 30 days after the event date.

A newborn child
Your newborn child is covered on your health plan for the first 60 days after birth and the following criteria are required:

- To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth
- You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent
- If you miss the deadline, your newborn will not have health benefits after the first 60 days

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:

- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are now eligible for state premium assistance under Medicaid or S-CHIP which will pay your premium contribution under this plan

We must receive the completed enrollment information within 60 days of the date when coverage ends.

Notification of change in status

Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:

- Change of address
- Dependent status change
- Dependent who enrolls in Medicare or any other health plan

Starting coverage

Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your policyholder to confirm your effective date.

Stopping coverage

Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making premium contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends.
  - You will need to complete a Declaration of Termination of Domestic Partnership.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your coverage ends* section for more information.

Why would we end your coverage?

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

Special coverage options after your coverage ends

When coverage may continue under the plan

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact the policyholder to see what options apply to you.

In some cases, premium payment is required for coverage to continue. Your coverage will continue under the plan as long as the policyholder and we have agreed to do so. It is the policyholder's responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and their covered dependents the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage.

The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

How you can extend coverage if you are totally disabled when coverage ends

Your coverage may be extended if you are totally disabled when coverage ends and you have been continuously insured for the 3 months prior to coverage ending.

You are "totally disabled" if you cannot work at your occupation or any other occupation for pay or profit.

Your dependent is "totally disabled" if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan

How you can extend coverage for your disabled child beyond the plan age limits

You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of intellectual or physical disability and depends mainly (more than 50% of their income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 60 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

How you can extend coverage when getting inpatient care when coverage ends

Your coverage may be extended if you are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren't extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

- When you are discharged
- When you no longer need inpatient care
- 12 months of coverage

The extension of benefits shall not extend the time period during which you may:

- Enroll for continuation coverage under any New Jersey Continuation law of COBRA
- Expand the benefits for such coverage nor
- Waive the requirements concerning the payment of premium contribution for any continuation for any continuation plan selected

Continuation of coverage during temporary lay-off or approved leave of absence
If your coverage would terminate due to a temporary lay-off or an approved absence, coverage may be continued for up to 60 days, or as otherwise agreed upon by the policyholder and Aetna, if the policyholder:

- Pays the premium for such continued coverage and
- Provides continued coverage from us or its other sponsored health benefit plans to all eligible enrollees in the same class as yours whose coverage would otherwise terminate because of a temporary lay-off or approved leave of absence.

How you can extend coverage for hearing services and supplies when coverage ends
If you are not totally disabled when your coverage ends, coverage for hearing services and supplies may be extended for 30 days after your coverage ends:

- If the **prescription** for the hearing aid is written during the 30 days before your coverage ends
- If the hearing aid is ordered during the 30 days before your coverage ends

How you can extend coverage for your child in college on medical leave
You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious illness or injury.
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as **medically necessary** due to serious illness or injury. The **physician** treating your child will be asked to keep us informed of any changes.

Over-age dependent continuation
Who is an over-age dependent child?
Your child by blood or law who:

- Has reached the limiting age as described in the *Who can be a dependent on this plan* section, but is less than 31 years of age
- Is not married or is not a domestic partner or in a civil union
- Has no dependents of their own
- Is either a resident of New Jersey or is enrolled as a full-time student at an accredited school
- Is not covered under any other:
  - Group or individual health benefits plan
  - Group health plan
  - Church plan or health benefits plan
- Is not entitled to Medicare on the date continuation coverage begins

How can you continue coverage for over-age dependents?
A child who meets these conditions may elect to be covered until their 31 birthday, subject to all of the following:

- The over-age dependent must provide evidence of prior creditable coverage or receipt of benefits under:
  - A group or individual health benefits plan
  - A group health plan
  - Church plan or health benefits plan or
  - Medicare
- The prior coverage must have been effective at some time prior to making an election for this over-age dependent coverage
- A parent of an over-age dependent must be enrolled as having elected dependent coverage at the time the over-age dependent elects continued coverage

The policyholder will validate dependent coverage for an over-age dependent's parent.

What is the effective date of over-age dependent continuation once elected?
The effective date of the of the continued coverage will be the later of:

- The date the over-age dependent gives written notice to us. The enrollee must complete the *HINT Supplemental Enrollment Information Form.*
- The date the over-age dependent pays the first premium
- The date the dependent would otherwise lose coverage due to attainment of the limiting age
  - The election must be made within 30 days prior to attainment of the limiting age to avoid lapse in coverage

If the dependent was not covered on the date of reaching the limiting age, the written election may be made at any time.

If the dependent did not qualify as an over-age dependent, but who subsequently meets all of the requirements, the written election may be made at any time after meeting all of the requirements.

Continued coverage
The continued coverage will be identical to the coverage provided to the over-age dependent's parent covered under the plan, however:

- If coverage is modified for dependents under the limiting age, the coverage for over-age dependents shall also be modified in the same manner.
- All cost sharing requirements will apply and will not combine with the parent's plan. Covered benefits incurred by the over-age dependent will not contribute towards the family deductible and out-of-pocket maximums.
- Family incurred expenses will not contribute towards the over-age dependent's deductibles or out-of-pocket maximums.
- The *When will your coverage end* and *When dependent coverage ends* provisions do not apply

The first month's premium will be determined by the effective date of the over-age dependent's election. Subsequent monthly premiums must be paid in advance, at the times and in the manner specified by Aetna. The grace period for the first premium payment is 31 days after the billing due date. We will bill the covered over-age dependent directly and the over-age dependent will remit the premium directly to us. Subsequent premium payment must be made within 31 day of the date the premium is due.

When does continuation end?
An over-age dependent's continued group health benefits end on the first of the following dates the over-age dependent:

- Attains age 31
- Marries, becomes a domestic partner, or enters into a civil union
- Acquires a dependent, including any newborn children
- Is no longer either a resident of New Jersey or enrolled as a full-time student at an accredited school
- Becomes covered under any other:
  - Group or individual health benefits plan
  - Group health plan
  - Church plan or health benefits plan
  - Becomes entitled to Medicare
- The end of the period for which premium has been paid for the over-age dependent subject to the grace period
- The date the plan ceases to provide coverage to the over-age dependent's parent who is covered under the plan
- The date the plan under which the over-age dependent elect to continue coverage is amended to eliminate coverage for dependents.
- The date the over-age dependent's parent who is covered under the plan waives dependent coverage. Except, if you have no other dependents, the over-age dependent's coverage will not end as a result of your waiving dependent coverage.

Over-age dependents who have made an election for continuation under this provision and whose coverage is later terminated are not eligible for continuation provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or New Jersey Continuation under the group plan.

Discontinuance and replacement provisions
This section determines a carrier's responsibility when one carrier's policy or contract replaces another carrier's plan providing similar types of coverage.

How is the responsibility between the prior carrier and new carrier determined?
Your prior carrier's responsibility:

- Claims incurred on the day prior to the new carrier's effective date
- You are totally disabled on the date prior carrier's plan ended
- Extension of benefits will remain the same if the group policyholder, contract holder or other entity:
  - Obtains replacement coverage from a new carrier
  - Decides to self-fund or
  - Decides to stop providing coverage

Your new carrier's responsibility:

- You are eligible for coverage with the new carrier on the effective date of the new carrier's plan
- You were covered under the prior plan on the date that plan ended and you are in an eligible class of covered employees on the effective date of the new carrier's plan

The minimum amount of benefits to be provided by the new carrier are the prior carrier's plan minus any benefits payable or services or supplies provided by the prior plan.

Coverage shall be provided by the prior carrier until at least the earliest of the following:

- The date the individual becomes eligible under the new carrier's plan
- For each type of coverage, the date the individual's coverage would terminate in accordance with the new carrier's termination provision (for example, at termination of employment or ceasing to be an eligible dependent, as the case may be)
- In the case of an individual who was totally disabled, and in the case of a type of coverage for which New Jersey law requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by New Jersey law

What happens to the time you have already satisfied for any benefit waiting periods?
The new carrier will give you credit for this time. Your employer will confirm the time already satisfied with the prior carrier.

What happens to any amount of your deductible satisfied with the prior plan?
Credit is given for expenses occurring and claimed under the prior carrier's plan during the 90 days before the effective date of the new carrier's plan. Keep in mind, the new carrier must have a similar deductible provision for these expenses to match.

In any situation where determination of the prior carrier's benefit is required by the new carrier, at the new carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit or the determination itself by the new carrier.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this certificate when we administer your coverage.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this.

Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *Complaints, claim decisions and appeal procedures section.* You cannot take any action until 60 days after we receive written submission of a claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examination and evaluations

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

- Names of **physicians** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an Aetna appeal

Some other money issues

Assignment of benefits

When you see a **network provider**, they will usually bill us directly.

When you assign your rights to receive reimbursement for covered services to an out of network provider, we are required to pay benefits in line with the assignment of benefits. We will directly pay the health care provider in the form of a check payable:

- To the health care provider or
- To the health care provider and you as a joint payee with signature lines for each.

Any payment made solely to you rather than the health care provider under these circumstances shall be considered unpaid, and unless remitted to the health care provider within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in the act.

Financial sanctions exclusions

If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **covered services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC).

You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Premium payments

Your plan requires that the policyholder make premium payments. We will not pay for benefits if premium payments are not made. Any decision to not pay benefits can be appealed.

Recovery of overpayments

We sometimes pay too much for **covered services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your **provider**, to return what we paid. However, we have to request reimbursement no more than 18 months following the date the first payment on the particular claim was made. We can only request one reimbursement per particular claim. We have the right to reduce any future benefit payments by the amount we paid by mistake.

We will work directly with your **provider** throughout the reimbursement process.

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our *Notice of Privacy Practices*. Just contact us.

When you accept coverage under this plan, you agree to let your **providers** share information with us. We need information about your physical and mental condition and care.

Effect of benefits under other plans

Health Maintenance Organization (HMO) plan

If you are eligible for and enrolled in coverage under an HMO plan offered by the policyholder, you will not have coverage under this plan (except for vision coverage if there is any) on the date that your HMO plan coverage starts. If you are pregnant when you change plans, you may be eligible for an extension of benefits. Contact us for more information.

Glossary

Allowable amount

See *How your plan works – What the plan pays and what you pay.*

Behavioral health provider

A **health professional** who is properly licensed or certified to provide **covered services** for **mental health conditions** and **substance use disorders** in the state where the person practices.

Brand-name prescription drug

An FDA-approved drug marketed with a specific name by the company that manufactures it; often the same company that developed and patents it.

Coinsurance

A percentage paid by a covered person for a **covered service**.

Copay, copayment

A dollar amount paid by a covered person for a **covered service**.

Covered service

The benefits, subject to varying cost shares, covered in this plan. These are:

- Described in the *Providing covered services* section
- Not listed as an exclusion in the *Coverage and exclusions – Providing covered services* section or the *General plan exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *How your plan works – Medical necessity and precertification requirements* section and the *Glossary* for more information

Deductible

The amount a covered person pays for **covered services** per year before we start to pay.

Detoxification

The process of getting a substance out of an addicted person's system and getting them physically stable.

Drug guide

A list of **prescription** drugs and devices established by us or an affiliate. It does not include all **prescription** drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to https://www.aetna.com/individuals-families/find-a-medication.html.

Emergency medical condition

A severe medical condition that:

- Comes on suddenly
- Needs immediate medical care
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Loss of a bodily function
  - Loss of function to a body part or organ
  - Danger to the health of an unborn baby

Emergency services

Treatment given in a **hospital's** emergency room. This includes evaluation of and treatment to stabilize the **emergency medical condition**.

Experimental and investigational

Drugs, treatments or tests not yet accepted by **physicians** or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

A drug, device, procedure, or treatment is **experimental and investigational** if:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental and investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental and investigational**.

Formulary exclusions list

A list of **prescription** drugs excluded from preferred cost-sharing. This list is subject to change.

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

A person who is authorized by law to provide health care services to the public; for example, **physicians**, nurses and physical therapists.

Home health care agency

An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

Hospital

An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can **stay** overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Infertile, infertility

A disease defined by one of the following:

- The failure to become pregnant;
- A male is unable to impregnate a female;
- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart
  - For an individual or their partner who has been clinically diagnosed with gender identity disorder
- Partners are unable to conceive as a result of involuntary medical sterility;
- A person is unable to carry a pregnancy to live birth; or
- A previous determination of infertility pursuant to this section

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Mail order pharmacy

A pharmacy where **prescription** drugs are legally dispensed by mail or another carrier.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most a covered person will pay per year in **copayments, coinsurance** and **deductible**, if any, for **covered services**.

Medically necessary, medical necessity

Health care services that a **provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, **physician** or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease
- With respect to **substance use disorder**, in accordance with an evidence - based and peer reviewed clinical review tool as designated in regulation by the Commissioner of Human Services

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Following the standards set forth in our clinical policies and applying clinical judgment
- With respect to **substance use disorder**, your provider will determine **medical necessity** for the first 180 days if treatment.

Mental health condition

A **mental health condition** as defined to be consistent with the most recent edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, and any subsequent editions published by the American Psychiatric Association.

Negotiated charge

See *How your plan works – What the plan pays and what you pay.*

Network provider

A **provider** listed in the directory for your plan. A National Advantage Program (NAP **provider)** listed in the NAP directory is not a **network provider**. A **network provider** can also be referred to as an in-network provider.

Out-of-network provider

A **provider** who is not a **network provider.**

Physician

A **health professional** trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Precertification, precertify

Pre-approval that you or your **provider** receives from us before you receive certain **covered services**. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Preferred drug

A **prescription** drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

Prescription

This is an instruction written by a **physician** that authorizes a patient to receive a service, supply, medicine or treatment.

Primary care physician (PCP)

A **physician** who:

- The directory lists as a **PCP**
- Is selected by a covered person from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to a covered person
- Shows in our records as your **PCP**

A **PCP** can be any of the following **providers**:

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group (primary care office)

Provider

A **physician, health professional,** person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare. With respect to the treatment of autism, the treatment must be administered directly by or under the direct supervision of an individual who is credentialed by the national Behavior Analyst Certification Board as either:

- a Board Certified Behavior Analyst – Doctoral (BCBA-D)
- a Board Certified Behavior Analyst – (BCBA)

Psychiatric hospital

An institution licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of **substance use disorders** or **mental health conditions.**

Residential treatment facility

An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for **mental health conditions** or **substance use disorder** residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:
For residential treatment programs treating **mental health conditions**:

- A **behavioral health provider** must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **substance use disorder** residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Retail pharmacy

An independent pharmacy, a supermarket pharmacy, a chain pharmacy or a mass merchandiser pharmacy having a state license to dispense medications to the general public at retail prices as a pharmacy. Retail community pharmacy does not include a pharmacy that dispenses prescription medications to patients primarily through mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

Room and board
An institution's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Same terms and conditions
With respect to the treatment of **mental health conditions** and **substance use disorders**, we will not apply more restrictive non-quantitative limitations or more restrictive quantitative limitations to **mental health conditions** and **substance use disorders**, than we apply to substantially all other medical or surgical benefits.

Semi-private room rate
An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, we will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility
A facility specifically licensed as a **skilled nursing facility** by applicable laws to provide skilled nursing care.
Skilled nursing facilities also include:

- Rehabilitation **hospitals**
- Portions of a rehabilitation **hospital**
- A **hospital** designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

It does not include institutions that primarily provide for the care and treatment of **mental health conditions** or **substance use disorders**.

Skilled nursing services
Services provided by a registered nurse or licensed practical nurse within the scope of their license.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drugs
These are **prescription** drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration. You can contact us to access the list of specialty drugs.

Specialty pharmacy
This is a pharmacy designated by us as a network pharmacy to fill prescriptions for **specialty prescription drugs**.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Step therapy

A form of **precertification** under which certain **prescription** drugs are excluded from coverage, unless a first-line therapy drug is used first by you. The list of **step therapy** drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to **step therapy** is available upon request or on our website at https://www.aetna.com/individuals-families/find-a-medication.html.

Substance use disorder

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent including withdrawal. These are defined to be consistent with the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM), and any subsequent editions published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental health condition** that are a focus of attention or treatment.

Surgery, surgical procedure

The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

Telehealth

The use of information and communication technologies, such as:

- Telephones
- Remote patient monitoring devices
- Other electronic means
- To support Clinical health care
- **Provider** consultation
- Patient and professional health-related education
- Public health
- Health administration
- Other services

in accordance with New Jersey state law.

Telemedicine

The delivery of **eligible health services** using:

- Electronic communications
- Information technology
- Other electronic or technological means

To bridge the gap between a **provider** and you, either with or without the assistance of another **provider** in accordance with New Jersey state law.

Telemedicine does not include the use, in isolation, of:

- Audio-only telephone conversation
- Electronic mail
- Instant messaging
- Phone text
- Facsimile transmission

Terminal illness

A medical prognosis that you are not likely to live more than 6-24 months.

Urgent condition

An illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**.

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- Physician's office
- Urgent care facility

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Benefit Mandates that apply to you based on where you live

There may be other state mandated benefits that apply to you if you do not live in the state of New Jersey. Please contact Member Services at the phone number listed on your ID card with any questions you may have on your plan of benefits.

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Disclosures to covered persons regarding out-of-network treatment

This summary only provides an overview of how a covered person's health benefits plan covers out-of-network treatment. It is only guidance to help a covered person understand their out-of-network benefits. This summary does not alter your coverage in any way.

The covered person should refer to their individual policy, group policy, certificate or evidence of coverage (if employer group plan), or summary of benefits and c overages for more information about your out-of-network benefits and about coverages and costs for in-network treatment.

For additional information – including whether a health care professional or facility is in-network or out-of-network, examples of out-of-network costs and estimates for specific services - please contact us at toll-free at the toll free number on your member identification card. The hours of operation are Monday to Friday, 5 am to 9 pm.

Or

Visit our website at: aetna.com
And select legal notices, state specific and scroll to New Jersey out-of-network claims.

Your policy covers:	What this means:	How am I protected by NJ law?
Medically necessary treatment on an emergency or urgent basis by out-of-network health care professionals/facilities	Emergency - You are covered for out-of- network treatment for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain; psychiatric disturbances and/or symptoms of substance use disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual or unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes if there is inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery or such transfer may pose a threat to the health or safety of the woman or unborn child. Urgent – You are covered for out-of-network treatment of a non-life-threatening condition that requires care by a health care professional	Except as discussed below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: **www.state.nj.us/dobi/consumer.htm.** Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the emergent/urgent medical services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of- pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled. If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the medical services. The amount awarded by the arbitrator may exceed what the carrier has

	within 24 hours.	already paid to the out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).

Your policy covers:	What this means:	How am I protected by NJ law?
Inadvertent out-of- network services	You are covered for treatment by an out-of- network health care professional for covered services when you use an in-network health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, in- network health care services are unavailable or provided by an out-of-network health care professional in that in-network facility. This includes laboratory testing ordered by an in- network health care professional and performed by an out-of-network bio- analytical laboratory (e.g., imaging, X-rays, blood tests, and anesthesia).	Except as provided below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: **https://www.state.nj.us/dobi/consumer.htm**
		Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the inadvertent out-of-network services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled.
		If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the inadvertent out-of- network services. The amount awarded by the arbitrator may exceed what the carrier has already paid to an out-of-network health care professional/facility; however, any

		additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).

Your policy covers:	**What this means:**	**How am I protected by NJ law?**
Treatment from out-of-network health care professionals/ facilities if in-network health care professionals/facilities are unavailable.	Plans are required to have adequate networks to provide you with access to professionals/facilities within certain time/distance requirements so you can obtain medically necessary treatment of all illnesses or injuries covered by your plan.	You can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, often called a request for an "in-plan exception." Please see the Department of Banking and Insurance's guide at: **https://nj.gov/dobi/appeal/**.

Your policy covers:	What this means:	How am I protected by NJ law?
Voluntary out-of-network services	You are covered for treatment by an out-of- network health care professional/facility when you knowingly, voluntarily and specifically select an out-of-network health care professional/facility, even if you have the opportunity to be serviced by an in- network health care professional/facility. We will cover voluntary out-of-network service at the plan coinsurance listed in your Schedule of Benefits. Member cost-share may vary by service and be subject to a plan deductible. Your Schedule of Benefits describes your cost-share for covered out of network services. Some covered out-of-network services require you to precertify them with Aetna. Please be advised that the allowed charge/amount (discussed above) is not the same as the amount billed by your Out-of-Network Health Care Professional/Facility, and is usually less. We calculate the allowed charge/ amount as explained in your Booklet/ Certificate. Please refer to the attached definition of recognized charges for details on how the plan pays covered voluntary out-of-network services.	Carriers must provide ready access to information about how to determine when a health care professional/facility is in- network. Please contact us if you have any questions about the status of a particular professional/facility. Additionally, health care professionals/ facilities must disclose to you, in writing or on a website, the plans in which they participate as in-network providers. Note, indications that a professional/facility "accepts" a certain health plan does not necessarily indicate in- network status. So, when seeking treatment, you can check with both us and your prospective health care professional/facility. Carriers must provide a method to enable you to be able to calculate an estimate of out-of-network costs when voluntarily seeking to use an out-of-network health care professional/facility. You can contact us via the methods above to obtain more information regarding the allowed charge/amounts for specific services if you can provide a current procedural terminology (CPT) code. If you do not have a CPT code, you can estimate your costs by: You can log into the Aetna secure member website to use the cost estimator tool to obtain an estimate of your costs for covered out of network services. If a service or procedure is not listed in the cost estimator tool in your secure member website, you can obtain an estimated cost by completing the appropriate Member Request for Estimate Form on our website. To use the cost estimator, please visit our site at: **https://www.aetna.com/health-care-professionals.html** and click the "login" button. For a price estimate form, please visit this section of **Aetna.com:** **https://www.aetna.com/individuals-families/member-rights-resources/rights/state-specific-information.html** Once on the page, scroll to New Jersey for

		the applicable form.
	You will be **responsible for payment of**: a) Your cost-sharing portion of the allowed charge/amount as disclosed above; PLUS, b) the difference between our allowed charge/amount and the amount the out-of-network health care professional/facility bills for the services (commonly referred to as the "balance bill").	You can also visit our website above for examples of the average costs (allowed charge/amount, billed amount, consumer responsibility without cost-sharing under plan) for ten more frequently billed out-of-network services.

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711,
Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697 (TDD).**

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). If there is any variance between this notice and the plan documents, the information in your plan documents govern.

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Important information about organ and tissue donation

Each year, we're required to send you informational materials about organ and tissue donation and registration. This is required* as your health benefits plan is written in New Jersey.

For information on how to make an anatomical gift, including information on the registration of a gift in the Donate Life New Jersey registry, please use the following contact information, depending on where you live:

If you live in northern or central New Jersey, contact:

New Jersey Sharing Network
691 Central Avenue, New Providence, NJ 07974
Phone: **(800) 742-7365**
Email: info@NJSharingNetwork.org
Web address: **www.NJSharingNetwork.org**

If you live in southern New Jersey, contact:

Gift of Life Donor Program
401 N. 3rd Street, Philadelphia, PA 19123
Phone: **(800) DONORS-1 (800) 366-6771**
Email: info@donors1.org
Web address: **www.donors1.org**

If you live in another state, please find the organization for your state online at:
https://organdonor.gov/awareness/organizations/local-opo.html

If you have any questions, please call our customer service department at the phone number on the back of your ID card. Thank you.

***This notice is sent in compliance with Chapter 220 of the New Jersey Laws of 2017.**
Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company of New York and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

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Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge.** The **recognized charge** may be less than the **provider's** full charge.

The **recognized charge** depends on the Geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	**Recognized charge**
Professional services and other services or supplies not mentioned below	The reasonable amount rate
Services of **hospitals** and other facilities	The reasonable amount rate
Prescription drugs	110% of the average wholesale price (AWP)
Important note: If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider**. NAP **providers** are **out-of-network providers** and third party vendors that have contracts with us but are not **network providers.**

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider's estimated costs for the service and leave the facility provider with a reasonable profit. For hospitals and other facilities which report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formula as needed to maintain the reasonableness of the recognized charge. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other providers charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate may be 105% of the rate CMS establishes for those services or supplies.
- For laboratory, our rate may be 75% of the rate CMS establishes for those services or supplies.
- For **DME**, our rate may be 75% of the rate CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate may be 100% of the rate CMS establishes for those medications.

Reasonable amount rate

- means your plan has established a reasonable rate amount as follows:

Service or supply	**Reasonable amount rate**
Professional services	The 80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically: ▪ We update our systems with these changes within 180 days after receiving them from FAIR Health. ▪ If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable. If the alternative data source does not contain a value for a particular service or supply, we will base the **recognized charge** on the Medicare allowed rate.
Inpatient and outpatient charges of **hospitals**	The Facility charge rate (FCR) rate
Inpatient and outpatient charges of facilities other than **hospitals**	The Facility charge rate (FCR) rate]

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits

We have online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on Aetna member website. **Aetna's** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna's member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.



Preferred Provider Organization (PPO) Medical Plan

Schedule of Benefits

Prepared exclusively for:

Policyholder:	Monroe Township Board of Education
Policyholder number:	GP-152709
Schedule of Benefits	3A Open Access Managed Choice - New Jersey Educator Health Plan
Group policy effective date:	July 1, 2020
Plan effective date:	January 1, 2021
Plan issue date:	May 28, 2021
Plan revision effective date:	July 1, 2021

Underwritten by Aetna Life Insurance Company in the state of New Jersey.

See *How to read your schedule of benefit* at the beginning of this schedule of benefits

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from a **network provider**.
  - "Out-of-network coverage", we mean you can get care from **providers** who are not **network providers**.
- The **deductibles** and **copayments/coinsurance** listed in the schedule of benefits below reflect the **deductibles** and **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **deductibles, copayments** and **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the member **coinsurance** percentage. This is the **coinsurance** amount you pay.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**
  - Maximums

Important note:
All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at www.aetna.com or at the toll-free number on your ID card.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

See *How to read your schedule of benefit* at the beginning of this schedule of benefits

Plan features	Deductible/Maximums	
	In-network coverage	**Out-of-network coverage**
Deductible		
You have to meet your Calendar Year **deductible** before this plan pays for benefits.		
Individual	$0 per Calendar Year	$350 per Calendar Year
Family	$0 per Calendar Year	$700 per Calendar Year

Maximum out-of-pocket limit		
Maximum out-of-pocket limit per Calendar Year.		
Individual	$500 per Calendar Year	$2,000 per Calendar Year
Family	$1,000 per Calendar Year	$5,000 per Calendar Year

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Preventive care and wellness		
Routine physical exams		
Routine physical exams performed at a physician office including screening for lead poisoning for children and follow up treatment for lead poisoned children.	0% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	Not covered
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit	Not covered
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Health wellness promotion programs		
Recommended immunizations for all adults	No charge	Not covered
Annual:		Not covered
• blood tests and lifestyle behavior counseling for covered persons age 20 and over	No charge	30% (of the **recognized charge**) per visit
• A pap smear for female covered persons age 20 and over	No charge	Not covered
• Stool examination for presence of blood for covered persons age 40 or over	No charge	30% (of the **recognized charge**) per visit
• A mammogram including a digital tomosynthesis for female covered persons age 40 or over	No charge	Not covered
Every 5 years:	No charge	Not covered
• Glaucoma test for covered persons age 35 and over		
• A left-sided colon examination of 35 or 60 centimeters for covered persons age 45 and over	No **deductible** applies	

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Preventive care immunizations		
Preventive care immunizations performed in a facility or at a physician's office	0% (of the **negotiated charge)** per visit No **deductible** applies	Not covered except covered persons through age 12 months: 30% (of the **recognized charge)** after the **deductible**
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.

Well woman preventive visits routine gynecological exams (including pap smears)		
Routine gynecological exams (including pap smears)	0% (of the **negotiated charge)** per visit No **deductible** applies	30% (of the **recognized charge)** after the **deductible**
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar year	1 visits	1 visits

Preventive screening and counseling services		
Preventive screening and counseling services: • Obesity and/or healthy diet counseling • Substance use disorders • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	0% (of the **negotiated charge)** per visit No **deductible** applies	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Obesity and/or healthy diet counseling maximums:		
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only *10* visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	Not covered
Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Misuse of alcohol and/or drugs maximums:		
Maximum visits per 12 months	5 visits	Not covered
Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Use of tobacco products maximums:		
Maximum visits per 12 months	8 visits	Not covered
Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Sexually transmitted infection counseling maximums:		
Maximum visits per 12 months	2 visits	Not covered
Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer maximums:		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)		
Routine mammograms	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) after the **deductible**
Prostate specific antigen tests	0% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Digital rectal exams	0% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Fecal occult blood tests	0% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Sigmoidoscopies	0% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Double contrast barium enemas	0% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Colonoscopies	0% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Computed tomography colonography every 5 years	0% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Lung cancer screening	0% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Lung cancer screening maximums	1 screening every 12 months	Not covered
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**		
Preventive care services only	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services – facility or office visits	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Lactation counseling services maximum per 12 months either in a group or individual setting	Unlimited	Unlimited
Breast feeding durable medical equipment		
Breast pump supplies and accessories	0% per item No **deductible** applies	30% (of the **recognized charge**) per item
Important note: See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Family planning services – female contraceptives		
Counseling services		
Female contraceptive counseling services office visit	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits	2 visits
Important note: Any visits that exceed the contraceptive counseling services maximum are covered under **physician** services office visits.		
Devices		
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	0% per item No **deductible** applies	30% (of the **recognized charge**) per visit
Voluntary sterilization (female)		
Inpatient	0% per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Outpatient	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage	Out-of-network coverage
Physicians and other health professionals		
Physicians and **specialists** office visits (non-surgical)		
Physician services		
PCP's office hours visits (non-surgical) non preventive care The copay is waived when no office service is billed	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Telemedicine and or **telehealth** consultations by Physician	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Maximum consultations per day	1	1
Allergy injections		
Performed at a **physician's, PCP** or **specialist** office when you do not see the **physician**	Covered according to the type of benefit and the place where the service is received. No **deductible** applies	30% (of the **recognized charge**) per visit
Immunizations that are not considered preventive care		
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialist		
Specialist office visits		
Office hours visits (non-surgical)	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Telemedicine and or **telehealth** consultations by **specialist**	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Maximum consultations per day	1	1

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Physician surgical services		
Physicians and **specialists** office visits		
Performed at a **physician's PCP** office	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Performed at a **specialist's** office	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Alternatives to physician office visits		
Walk-in clinic visits		
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage	Out-of-network coverage
Hospital and other facility care		
Hospital care		
Inpatient **hospital**	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Anesthesia and hospital charges for dental care		
Hospital charges	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Home health care		
Outpatient	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
	Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours. Intermittent visits are considered periodic and recurring visits that skilled nurses or home health aides make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours. Intermittent visits are considered periodic and recurring visits that skilled nurses or home health aides make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge
Hospice care		
Inpatient facility	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Maximum days per lifetime	Unlimited	Unlimited

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Hospice care		
Outpatient	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day
Outpatient private duty nursing		
Outpatient private duty nursing	10% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Skilled nursing facility		
Inpatient facility	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Maximum days per Calendar Year	120	60

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Emergency services		
Hospital emergency room No copayment if admitted	$125 Copayment per visit	$125 Copayment per visit
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Important Note:

- As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share, (**deductible, copayment,** and **coinsurance**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.
- A separate **hospital** emergency room **copayment/coinsurance** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment/coinsurance** will be waived and your inpatient **copayment/coinsurance** will apply.

Urgent care		
Urgent medical care (at a non-**hospital** free standing facility)	$15 per visit No **deductible** applies	30% (of the **recognized** charge) per visit
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	Not covered	Not covered

A separate urgent care **deductible** or **copayment/coinsurance** will apply for each visit to an **urgent care provider**.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions		
Autism spectrum disorder or pervasive developmental disabilities		
Treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Diagnosis and testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical and occupational therapy	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Speech therapy	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
If your dependent receives services through the New Jersey Early Intervention System the portion of the family cost share related to such services is a **covered benefit**. Refer to the Schedule of Benefits under Primary Care Physician visit for the family cost share.		
Birthing center		
Inpatient	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Diabetic equipment, supplies and education		
Diabetic equipment and education	10% (of the **negotiated charge**) per visit	30% (of the **recognized charge**) per visit
Diabetic supplies	10% (of the **negotiated charge**) No **deductible** applies	30% (of the **recognized charge**) after the **deductible**

Family planning services - other		
Voluntary sterilization		
Outpatient	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Abortion		
Outpatient	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Outpatient infertility services		
Infertility diagnosis and treatment of underlying medical condition	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Comprehensive infertility treatment	$15 **copayment** per visit	30% of the **recognized charge** after the **deductible**
ART	$15 **copayment** per visit	30% of the **recognized charge** after the **deductible**
Jaw joint disorder treatment		
Jaw joint disorder treatment	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Maternity and related newborn care		
Inpatient	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Delivery services and postpartum care services		
Performed in a facility or at a **physician's** office	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Mental health treatment - inpatient		
Inpatient **mental disorders** during a **hospital** confinement Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Mental health treatment - outpatient		
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** (includes **telemedicine** and/ or **telehealth**) consultations Coverage is provided under the same terms, conditions as any other **illness**.	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** (includes **telemedicine** and/ or **telehealth**) cognitive behavior therapy consultations	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit

Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Substance related disorders treatment - inpatient		
Inpatient **substance abuse** detoxification during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Substance use disorders treatment - outpatient: detoxification and rehabilitation		
Outpatient **substance use disorders** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** and/or **telehealth** consultation) Coverage is provided under the same terms, conditions as any other **illness.**	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Outpatient **substance use disorders** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** and/or **telehealth** cognitive behavioral therapy consultations	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Other outpatient **substance use disorders** services **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling services	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Obesity surgery		
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Outpatient obesity surgery		
	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Pregnancy complications		
Inpatient	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive breast surgery		
Reconstructive breast **surgery**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery and supplies		
Reconstructive **surgery**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	Network (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage
Transplant services facility and non-facility			
Inpatient **hospital** transplant services	0% (of the **negotiated charge**) per transplant No **deductible** applies	30% (of the **negotiated charge**) per transplant	30% (of the **recognized charge**) per transplant
Wilm's tumor	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **negotiated charge**) per admission	30% (of the **recognized charge**) per admission
Physician services including office visits	$15 per visit No **deductible** applies	30% (of the **negotiated charge**) per visit	30% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests		
Outpatient diagnostic testing		
Acupuncture and acupuncture therapy		
Acupuncture	$15 **copayment** per visit	Lesser of $60 **copayment** per visit or 75% of the **negotiated charge**
Diagnostic complex imaging services		
	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Diagnostic lab work		
	0% (of the **negotiated** charge) per visit No **deductible** applies	30% (of the **recognized** charge) per visit
Diagnostic radiological services		
	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Orally-administered anti-cancer prescription drug services		
Orally-administered anti-cancer prescription drug services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Outpatient infusion therapy		
Performed in a **physician's** office	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Performed in a person's home	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Performed in the outpatient department of a **hospital**	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Performed at an outpatient facility other than the outpatient department of a **hospital**	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Outpatient radiation therapy		
Radiation therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Pulmonary rehabilitation		
Pulmonary rehabilitation	$15 per visit No **deductible** applies	30% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Short-term rehabilitation services		
Outpatient Physical, Occupational and Speech Therapies		
Outpatient speech and occupational therapy	$15 **copayment** per visit	30% (of the **recognized charge)** after the **deductible**
Outpatient physical therapy	$15 **copayment** per visit	Lesser of $52 **copayment** per visit or 75% (of the **negotiated charge)**
Therapeutic manipulation		
Therapeutic manipulation	$15 **copayment** per visit	Lesser of $35 **copayment** per visit or 75% (of the **negotiated charge)**
Maximum visits per Calendar Year	30	30
Habilitation therapy services		
	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage	Out-of-network coverage
Other services		

Ambulance service		
Ambulance	10% (of the **negotiated charge**) per trip No **deductible** applies.	30% (of the **recognized charge**) per trip .
Clinical trial therapies (experimental or investigational)		
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)		
DME	10% (of the **negotiated charge**) per item No **deductible** applies.	30% (of the **recognized charge**) per item
Hearing aids and exams		
Hearing aid exams	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Hearing aids Covered persons through age 15 years and younger	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Hearing aids	One per ear every 24 month consecutive period	One per ear every 24 month consecutive period
Maximum per hearing aid	$1,000	$1,000

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Home hemophilia treatment		
Home treatment	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit

Nutritional supplements		
Nutritional supplements including those used for Inherited Metabolic Disease	0% (of the **negotiated charge**) per item No **deductible** applies	30% (of the **recognized charge**) per item

Infant formulas		
Infant formulas	0% (of the **negotiated charge**) per item No **deductible** applies	0% (of the **recognized charge**) per item No **deductible** applies
Infant pasteurized donated breast milk	0% (of the **negotiated charge**) per item No **deductible** applies	0% (of the **recognized charge**) per item No **deductible** applies

Sickle cell anemia		
Medical expenses and prescription drugs for treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Osteoporosis		
Physician's office visits	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit

Vision care		
Routine vision exams (including refraction)		
Routine vision exams including refraction	$15 **copayment** per visit	Not covered
Maximum visits per Calendar Year	1 visit	Not covered

See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	Network coverage	Out-of-network coverage
Outpatient prescription drugs		
Plan features	**Deductible/Copayment/Coinsurance/Maximums**	
Deductible waiver		
The calendar year **deductible** is waived for all **prescription drugs**.		
Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs		
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** will be paid at 100%.		
Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs		
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%.		
Deductible and copayment/coinsurance waiver for contraceptives		
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to female contraceptives when obtained at a **network pharmacy**. This means that such contraceptives will be paid at 100% for: • Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method paid at 100%. The Calendar Year **deductible** and the per **prescription copayment/coinsurance** continue to apply to **prescription drugs** that have a generic equivalent or generic alternative available obtained at a **network pharmacy** unless you are granted a medical exception.		
Outpatient prescription drug maximum out-of-pocket limit		
Outpatient **prescription drug maximum out-of-pocket limit** per calendar year		
Individual	$1,600 per calendar year	Unlimited
Family	$3,200 per calendar year	Unlimited
The amount of the family outpatient prescription drug maximum out-of-pocket limit that an individual must meet in a calendar year will not be greater than the individual out-of-pocket limit permitted by law.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Important note regarding out-of-network providers		
Review the *How to access out-of-network pharmacies* section of the booklet-certificate for more information on how these **pharmacies** are subject to higher out-of-pocket costs.		
Generic prescription drugs		
30 day supply filled at a **retail pharmacy**	$5 **copayment**	$5 **copayment** plus the amount above the **recognized charge.**
For a 31-90 day supply from a **retail pharmacy** or a CVS Caremark® **mail order** pharmacy	$10 **copayment**	$10 **copayment** plus the amount above the **recognized charge.**
Preferred prescription drugs		
30 day supply filled at a **retail pharmacy**	$10 **copayment**	$10 **copayment** plus the amount above the **recognized charge.**
31-90 day supply filled at a **retail pharmacy** or a CVS Caremark® **mail order pharmacy**	$20 **copayment**	$20 **copayment** plus the amount over the **recognized charge**
30-90 day supply filled at a **specialty pharmacy**	$20 **copayment**	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
More than a 30 day supply but less than a 61 day supply filled at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
More than a 60 day supply but less than a 91 day supply filled at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a **pharmacy**	0% per **prescription** or refill No **deductible** applies	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	0% per **prescription** or refill No **deductible** applies	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy**	$0 per **prescription** or refill No **deductible** applies	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.
If a **prescriber** prescribes a covered **brand-name prescription drug** where **a generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If a **prescriber** does not specify DAW and you request a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available, you will be responsible for the cost difference between **the brand-name prescription drug** and the **generic prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- Maximums

that are listed in the first part of this schedule of benefits.

Deductible provisions

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/coinsurance** for **eligible health services** to which the **deductible** does not apply.

Individual
This is the amount you owe for out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Family
This is the amount you and your covered dependents owe for out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments

Copayment
As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

Coinsurance

The specific percentage you and the plan have to pay for a health care service listed in the schedule of benefits.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits.

Maximum out-of-pocket limits provisions

Eligible health services applied to the **out-of-network maximum out-of-pocket limit** will not be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will not be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/coinsurance** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual
Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family
Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/coinsurance** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- All costs for non-emergency use of the emergency room
- All costs incurred for non-urgent use of an **urgent care provider**
- Any out of pocket costs for outpatient **prescription drugs**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits.

Maximum provisions
Eligible health services applied to the **out-of-network** maximum will be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will be applied to satisfy the **out-of-network** maximum.
Calculations; determination of recognized charge; determination of benefits provisions
Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits.

General coverage provisions

This section provides detailed explanations about the:

- Outpatient **prescription drug maximum out-of-pocket limits**

Outpatient prescription drug maximum out-of-pocket limits provisions

The outpatient **prescription drug maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/coinsurance** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family outpatient **prescription drug maximum out-of-pocket limit**. As to the individual outpatient **prescription drug maximum out-of-pocket limit** each of you must meet your outpatient **prescription drug maximum out-of-pocket limit** separately.

Individual
Once the amount of the **copayments/coinsurance** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of the **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family
Once the amount of the **copayments/coinsurance** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family outpatient **prescription drug maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family outpatient **prescription drug maximum out-of-pocket limit** is a cumulative outpatient **prescription drug maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual outpatient **prescription drug maximum out-of-pocket limit** amount in a Calendar Year.

The outpatient **prescription drug maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the outpatient **prescription drug maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/coinsurance** for that covered benefit will not count toward satisfying the outpatient **prescription drug maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the outpatient **prescription drug maximum out-of-pocket limit**. These include:

- All costs for non-covered services

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits.

Schedule of Benefits

Prepared for:

Policyholder:	Monroe Township Board of Education
Policyholder number:	GP-152709
Plan name:	Open Access Elect Choice Plan
Summary of Coverage:	1A
Group policy effective date:	July 1, 2020
Plan effective date:	July 1, 2020
Plan issue date:	May 28, 2021
Plan revision effective date:	July 1, 2021

Underwritten by Aetna Life Insurance Company in the state of New Jersey



Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- **Coinsurance** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**. You are responsible to pay any **deductibles**, **copayments** and remaining **coinsurance**, if they apply and before the plan will pay for any **covered services**.
- When a **covered service** shows "no charge", this means you have no responsibility for **deductibles**, **copayments** or **coinsurance**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

  See the schedule of benefits for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

Important note:
Covered services are subject to the Calendar Year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule of benefits.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works

This schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your certificate.

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Maximum out-of-pocket type	Designated provider
Individual	$2,500 per year
Family	$5,000 per year

Outpatient prescription drug maximum out-of-pocket limit

Individual	$3,000 per year
Family	$6,000 per year

General coverage provisions

This section explains the **maximum out-of-pocket limit** and limitations listed in this schedule.

Copayment

This is a dollar amount you pay for a **covered service**.

Coinsurance

This is a percentage you pay for a **covered service**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit provisions

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **deductibles, copayments**, and **coinsurance**, if any, for **covered services**.

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services which are identified in the certificate and the schedule
- Charges, expenses or costs in excess of the **allowable amount**
- Costs for non-emergency use of the emergency room

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group policy.

Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share and **deductible** you have paid during the year for **covered services** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that apply toward the limit for you for the remainder of the year.

Family prescription drug maximum out-of-pocket limit
After the amount of the cost share you and your covered dependent pay for **covered services** during the year meets the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

This plan has an individual and family **prescription** drug **maximum out-of-pocket limit**

The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **prescription** drug **maximum out-of-pocket limit** is met by a combination of family members with no single person in the family contributing more than the individual **maximum out-of-pocket limit** in a year.

The **maximum out-of-pocket limit** may not apply to certain **covered services**. If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit**.

All costs for non-covered services do not apply toward the **maximum out-of-pocket limit**.

Covered services

Description	Designated provider
Acupuncture	0% of the **negotiated charge** per visit, no **deductible** applies

Ambulance services

Description	Designated provider
Emergency services	0% of the **negotiated charge** per trip, no **deductible** applies
Non-emergency services	0% of the **negotiated charge** per trip, no **deductible** applies

Applied behavior analysis

Description	Designated provider
Applied behavior analysis	Covered based on type of service and where it is received

Clinical trials

Description	Designated provider
Experimental and investigational therapies	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received

Dental care anesthesia

Description	Designated provider
Hospital charges	Covered based on type of service and where it is received

Diabetic services, supplies, equipment, and self-care programs

Description	Designated provider
Diabetic services	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	Designated provider
DME	0% of the **negotiated charge** per item, no **deductible** applies

Emergency services

Description	Designated provider	Out-of-network
Emergency room	$100 per visit, no **deductible** applies	Paid same as designated provider
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note:
Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** as an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Foot orthotic devices

Description	Designated provider
Orthotic devices	$20 per visit, no **deductible** applies

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	Designated provider
PT, OT therapies	Covered based on type of service and where it is received

Speech therapy

Description	Designated provider
Speech therapy	Covered based on type of service and where it is received

Hearing aids

Description	Designated provider
Hearing aids	$20 per visit, no **deductible** applies
Age limit	Covered persons through age 15
Frequency limit	One per ear every 24 months
Benefit limit	$1,000

Hearing exams

Description	Designated provider
Hearing exams	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	Designated provider
Home health care	0% of the **negotiated charge** per visit, no **deductible** applies

Visit limit per day	3 visits

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

Home hemophilia treatment

Description	Designated provider
Home treatments	0% of the **negotiated amount** per visit, no **deductible** applies

Hospice care

Description	Designated provider
Inpatient services - **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies

Description	Designated provider
Outpatient services	0% of the **negotiated charge** per visit, no **deductible** applies

Visit limit per year	unlimited

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

Hospital care

Description	Designated provider
Inpatient services – **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies

Infertility services

Description	Designated provider
Treatment of **infertility**	Covered based on type of service and where it is received

Advanced reproductive technology (ART)

For this benefit, lifetime means any covered benefits paid under this plan, another plan with Aetna or plan associated with us, with the same policyholder.

Description	Designated provider
	$40 per visit, no **deductible** applies

Maternity and related newborn care

Includes complications

Description	Designated provider
Inpatient services – **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies
Services performed in **physician** office or a facility	0% of the **negotiated charge** per visit, no **deductible** applies
Services performed in **specialist** office or a facility	0% of the **negotiated charge** per visit, no **deductible** applies
Other services and supplies	Covered based on type of service and where it is received

Maternity and related newborn care important note:
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.

Mental health conditions

Mental health treatment

Coverage provided under the **same terms and conditions** as for any other condition

Description	Designated provider
Inpatient services-**room and board** including **residential treatment facility**	0% of the **negotiated charge** per admission, no **deductible** applies

Description	Designated provider
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** and/or **telehealth** consultation	0% of the **negotiated charge** per visit, no **deductible** applies
Outpatient mental health **telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	0% of the **negotiated charge** per visit, no **deductible** applies

Description	Designated provider
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	0% of the **negotiated charge** per visit, no **deductible** applies

Autism spectrum disorder or other developmental disabilities

Description	Designated provider
Diagnosis and testing	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received
Outpatient occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received

Substance use disorders treatment
Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided under the **same terms and conditions** as for any other condition

Description	Designated provider
Inpatient services-**room and board** during a **hospital stay**	0% of the **negotiated charge** per admission, no **deductible** applies

Description	Designated provider
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** and/or **telehealth** consultation	0% of the **negotiated charge** per visit, no **deductible** applies
Outpatient **telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	0% of the **negotiated charge** per visit, no **deductible** applies

Description	Designated provider
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support service	0% of the **negotiated charge** per visit, no **deductible** applies

Nutritional support

Description	Designated provider
Nutritional support	Covered based on type of service and where it is received

Obesity surgery

Description	Designated provider
Inpatient services – **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies

Description	Designated provider
Outpatient services	0% of the **negotiated charge** per visit, no **deductible** applies

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Designated provider
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received

Outpatient surgery

Description	Designated provider
At **hospital** outpatient department	$200 per visit, no **deductible** applies
At facility that is not a **hospital**	$100 per visit, no **deductible** applies

Physician services

Physician services-general or family practitioner

Description	Designated provider
Physician office hours (not surgical, not preventive) Includes **telemedicine** and/or **telehealth** consultation	$20 per visit, no **deductible** applies
Physician home visit (not preventive)	0% per visit, no **deductible** applies
Physician surgical services	$20 per visit, no **deductible** applies

Description	Designated provider
Physician telemedicine and/or **telehealth** consultation	$20 per visit, no **deductible** applies

Description	Designated provider
Physician visit during inpatient **stay**	0% of the **negotiated charge** per visit no **deductible** applies

Physician Services -Specialist

Description	Designated provider
Specialist office hours (not surgical, not preventive)	$40 per visit, no **deductible** applies
Specialist home visit (not preventive)	0% of the **negotiated charge** per visit, no **deductible** applies
Specialist surgical services	$40 per visit, no **deductible** applies

Description	Designated provider
Specialist telemedicine and/or **telehealth** consultation	$40 per visit, no **deductible** applies

Physician services -all other services not shown above

Description	Designated provider
All other services	Covered based on type of service and where it is received.

Prescription drugs – outpatient

Generic prescription drugs

Description	In-network
30 day supply filled at a **retail pharmacy**	$15, no **deductible** applies
More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy**	$30, no **deductible** applies
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	$45, no **deductible** applies
More than a 60 day supply but less than a 91 day supply at a **mail order pharmacy**	$0, no **deductible** applies

Preferred prescription drugs

Description	In-network
30 day supply filled at a **retail pharmacy**	$25, no **deductible** applies
More than 30 day supply but less than 61 day supply at a **retail pharmacy**	$50, no **deductible** applies
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	$75, no **deductible** applies
More than 60 day supply but less than 91 day supply at a **mail order pharmacy**	$10, no **deductible** applies

Other covered services

Anti-cancer drugs taken by mouth

Description	In-network
30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above
More than 60 day supply but less than 91 day supply at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above
More than 30 day supply but less than 91 day supply at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits, above

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network
30 day or 6 month supply of generic and OTC drugs and devices	$0, no **deductible** applies
30 day or 6 month supply of **brand-name prescription drugs** and devices	Paid according to the type of drug per the schedule of benefits, above

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	$0, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section

Risk reducing breast cancer drugs

Description	In-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section

Tobacco cessation drugs

Description	In-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

Preventive care

Description	Designated provider
Preventive care services	0% of the **negotiated charge** per visit, no **deductible** applies
Breast-feeding support and counseling services	0% of the **negotiated charge** per visit, no **deductible** applies
Breast-feeding support and counseling services limit per year	6 visits in a group or individual setting **Telemedicine** and/or **telehealth** visits do not apply toward your visit limit. All other visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	**Important note:** You are limited to 2 breast pump kits per birth • The purchase of an electric or manual breast pump, including supplies and accessories • The purchase or rental of a multi-user breast pump, including supplies and accessories
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump
Counseling for substance use disorder	0% of the **negotiated charge** per visit, no **deductible** applies
Counseling substance use disorder visit limit	5 visits/12 months
Counseling for genetic risk for breast and ovarian cancer	0% of the **negotiated charge** per visit, no **deductible** applies
Counseling for genetic risk for breast and ovarian cancer visit limit	5 visits/12 months
Counseling for obesity, healthy diet	0% of the **negotiated charge** per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	26 visits/12 months Of the total visits allowed per year, 10 may be used for high cholesterol and other known risk factors for heart disease and diet-related chronic diseases
Counseling for sexually transmitted infection	0% of the **negotiated charge** per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Family planning services (contraceptive counseling)	0% of the **negotiated charge** per visit, no **deductible** applies
Family planning services (contraceptive counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	0% of the **negotiated charge,** no **deductible** applies

Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Prescription and OTC contraceptives (birth control)	0% of the **negotiated charge**
Preventive care drugs and supplements	0% of the **negotiated charge,** no **deductible** applies
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	0% of the **negotiated charge,** no **deductible** applies
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care tobacco cessation **prescription** and OTC drugs	0% of the **negotiated charge,** no **deductible** applies
Limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Routine cancer screenings	0% of the **negotiated charge** per visit, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Limit per screening	1 visit
Lung cancer screening	0% of the **negotiated charge** per visit, no **deductible** applies
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing

Routine physical exam	0% of the **negotiated charge** per visit, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year 3 exams every 12 months age 1-2 3 exams every 12 months age 2-3 and 1 exam every 12 months after that age up to age 22 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman preventive visits	0% of the **negotiated charge** per visit, no **deductible** applies
Well woman preventive visits limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 visit

Private duty nursing - outpatient

Up to eight hours equals one shift

Description	Designated provider
Outpatient services	0% of the **negotiated charge** per visit, no **deductible** applies

Visit/shift limit per year	70

Prosthetic devices

Description	Designated provider
Prosthetic devices	$20 per item, no **deductible** applies

Reconstructive surgery and supplies

Including breast **surgery**

Description	Designated provider
Surgery and supplies	Covered based on type of service and where it is received

Short-term cardiac and pulmonary rehabilitation services

Cardiac Rehabilitation

Description	Designated provider
Cardiac rehabilitation	Covered based on type of service and where it is received

Pulmonary Rehabilitation

Description	Designated provider
Pulmonary	Covered based on type of service and where it is received

Short-term rehabilitation services

Cognitive Rehabilitation

Description	Designated provider
Cognitive Rehabilitation	Covered based on type of service and where it is received

Spinal Manipulation

Description	Designated provider
Spinal Manipulation	$20 per visit, no **deductible** applies
Visit limit per year	25

Physical, Occupational and Speech Therapies

Description	Designated provider
PT, OT and ST	$20 per visit; no **deductible** applies

Physical, occupational and speech therapies

Description	Designated provider
Visit limit per year	90

Sickle cell anemia

Description	Designated provider
Medical expenses and **prescription** drugs for treatment	Covered based on type of service and where it is received

Skilled nursing facility

Description	Designated provider
Inpatient services - **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies
Other inpatient services and supplies	0% of the **negotiated charge** per admission, no **deductible** applies

Day limit per year	120

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	Designated provider
	0% of the **negotiated charge** per visit, no **deductible** applies

Diagnostic lab work

Description	Designated provider
	0% of the **negotiated charge** per visit, no **deductible** applies

Diagnostic x-ray and other radiological services

Description	Designated provider
	0% of the **negotiated charge** per visit, no **deductible** applies

Therapies

Chemotherapy

Description	Designated provider
Chemotherapy services	Covered based on type of service and where it is received

Infusion

Outpatient services

Description	Designated provider
	Covered based on type of service and where it is received

Radiation therapy

Description	Designated provider
Radiation therapy	Covered based on type of service and where it is received

Transplant services

Description	Designated provider (IOE facility)
Inpatient services and supplies	0% of the **negotiated charge** per transplant, no **deductible** applies
Physician services	Covered based on type of service and where it is received

Transplant important note:
See the *Transplant services* benefit in the *Coverage and exclusions* section of the certificate for more information. The limit applies to all transplant services received while you are a member of an Aetna plan or one associated with us. The plan **lifetime maximum**, if any, will not apply to transplant services. The transplant limit will apply.

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	Designated provider	Out-of- network
Urgent care facility	$40 per visit, no **deductible** applies	Paid same as designated provider

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	Designated provider
	0% per visit, no **deductible** applies

Visit limit	1 visit every 12 months

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

Description	Designated provider
Non-emergency services	$20 per visit, no **deductible** applies
Preventive immunizations	0% of the **negotiated charge** per visit, no **deductible** applies
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Screening and counseling services	0% per visit, no **deductible** applies
Screening and counseling limits	See the *Preventive care services* section of the SOB

Schedule of Benefits

Prepared for:

Policyholder:	Monroe Township Board of Education
Policyholder number:	GP-152709
Plan name:	Open Access Managed Choice $10 Plan
Summary of Coverage:	2A
Group policy effective date:	July 1, 2020
Plan effective date:	July 1, 2020
Plan issue date:	May 28, 2021
Plan revision effective date:	July 1, 2021

Underwritten by Aetna Life Insurance Company in the state of New Jersey



Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles, copayments** or **coinsurance**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- **Coinsurance** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**. Sometimes for out-of-network services, your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **coinsurance** percentage that your plan will pay. You are responsible to pay any **deductibles, copayments** and remaining **coinsurance**, if they apply and before the plan will pay for any **covered services**.
- When a **covered service** shows "no charge", this means you have no responsibility for **deductibles, copayments** or **coinsurance**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between in-**network** and **out-of-network providers**
  - Separate limits for in-**network** and **out-of-network providers**
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

  See the schedule of benefits for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

Important note:
Covered services are subject to the Calendar Year **deductible, maximum out-of-pocket,** limits, **copayment** or **coinsurance** unless otherwise stated in this schedule of benefits.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **coinsurance** you pay when you get **covered services** from an in-**network, out-of-network provider**. This schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works

This schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your certificate.

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features

Precertification covered services reduction

This only applies to **out-of-network covered services**:
Your certificate contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

If **precertification** for **covered services** isn't completed, when required, it can result in any of the following benefit reductions:

- **Covered services** reduced by the lesser of 50% of the benefit that would have been payable or $400. The reduction will not exceed 50% of the charges which would otherwise be covered under the plan.

You may have to pay an additional portion of the **allowable amount** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network	Out-of-network
Individual	$0 per year	$200 per year
Family	$0 per year	$400 per year

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$3,000 per year	$1,200 per year
Family	$6,000 per year	$2,400 per year

Outpatient prescription drug maximum out-of-pocket limit

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$3,000 per year	$3,000 per year
Family	$6,000 per year	$6,000 per year

General coverage provisions

This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

Out-of-network **covered services** will apply only to the out-of-network **deductible**.

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **coinsurance**, if any, for these **covered services**.

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Deductible credit

If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Copayment

This is a dollar amount you pay for a **covered service**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**.

Coinsurance

This is a percentage you pay for a **covered service**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit provisions

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **deductibles, copayments**, and **coinsurance**, if any, for **covered services**.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services which are identified in the certificate and the schedule
- Charges, expenses or costs in excess of the **allowable amount**
- Costs for non-emergency use of the emergency room

Limit provisions – maximum out of pocket

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group policy.

Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share and **deductible** you have paid during the year for **covered services** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that apply toward the limit for you for the remainder of the year.

Family prescription drug maximum out-of-pocket limit

After the amount of the cost share you and your covered dependent pay for **covered services** during the year meets the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

This plan has an individual and family **prescription** drug **maximum out-of-pocket limit**

The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **prescription** drug **maximum out-of-pocket limit** is met by a combination of family members with no single person in the family contributing more than the individual **maximum out-of-pocket limit** in a year.

The **maximum out-of-pocket limit** may not apply to certain **covered services**. If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit**.

All costs for non-covered services do not apply toward the **maximum out-of-pocket limit**.

Covered services

Description	In-network	Out-of-network
Acupuncture	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Ambulance services

Description	In-network	Out-of-network
Emergency services	20% of the **negotiated charge** per trip, no **deductible** applies	Paid same as in-network
Non-emergency services	20% of the **negotiated charge** per trip, no **deductible** applies	20% of the **allowable amount** per trip after **deductible**

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Clinical trials

Description	In-network	Out-of-network
Experimental and investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Dental care anesthesia

Description	In-network	Out-of-network
Hospital charges	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Diabetic services, supplies, equipment, and self-care programs

Description	In-network	Out-of-network
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	0% of the **negotiated charge** per item, no **deductible** applies	20% of the **allowable amount** per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$50 per visit, no **deductible** applies	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note:
Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** as an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Foot orthotic devices

Description	In-network	Out-of-network
Orthotic devices	$10 per visit, no **deductible** applies	20% of the **allowable amount** per item after **deductible**

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network	Out-of-network
PT, OT therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Speech therapy

Description	In-network	Out-of-network
Speech therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing aids

Description	In-network	Out-of-network
Hearing aids	$10 per visit, no **deductible** applies	20% of the **allowable amount** per item after **deductible**
Age limit	Covered persons through age 15	Covered persons through age 15
Frequency limit	One per ear every 24 months	One per ear every 24 months
Benefit limit	$1,000	$1,000

Hearing exams

Description	In-network	Out-of-network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Visit limit per day	3 visits	3 visits
Visit limit per year	90	90

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

Home hemophilia treatment

Description	In-network	Out-of-network
Home treatments	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	20% of the **allowable amount** per admission after **deductible**
Outpatient services	0% of the **negotiated charge** per visit, no **deductible applies**	20% of the **allowable amount** per visit, after **deductible**
Visit limit per year	unlimited	unlimited

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

Hospital care

Description	In-network	Out-of-network
Inpatient services - **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	20% of the **allowable amount** per admission after **deductible**

Infertility services

Description	In-network	Out-of-network
Treatment of **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Advanced reproductive technology (ART)

For this benefit, lifetime means any covered benefits paid under this plan, another plan with Aetna or plan associated with us, with the same policyholder.

Description	In-network	Out-of-network
	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	20% of the **allowable amount** per admission after **deductible**
Services performed in **physician** office or a facility	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Services performed in **specialist** office or a facility	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Other services and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Maternity and related newborn care important note:
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.

Mental health conditions

Mental health treatment

Coverage provided under the **same terms and conditions** as for any other condition

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	0% of the **negotiated charge** per admission, no **deductible** applies	20% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** and/or **telehealth** consultation	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Outpatient mental health **telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Autism spectrum disorder or other developmental disabilities

Description	In-network	Out-of-network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Outpatient occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Substance use disorders treatment
Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided under the **same terms and conditions** as for any other condition

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	0% of the **negotiated charge** per admission, no **deductible** applies	20% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** and/or **telehealth** consultation	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Outpatient **telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Nutritional support

Description	In-network	Out-of-network
Nutritional support	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	20% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Physician services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not surgical, not preventive) Includes **telemedicine** and/or **telehealth** consultation	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Physician home visit (not preventive)	0% of the **negotiated charge** per visit no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Physician surgical services	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine and/or **telehealth** consultation	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit, after **deductible**

Physician Services-Specialist

Description	In-network	Out-of-network
Specialist office hours (not surgical, not preventive)	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Specialist home visit (not preventive)	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Specialist surgical services	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine and/or **telehealth** consultation	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Physician services -all other services not shown above

Description	In-network	Out-of-network
All other services	Covered based on type of service and where it is received.	Covered based on type of service and where it is received.

Prescription drugs – outpatient

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply filled at a **retail pharmacy**	$15, no **deductible** applies	$15, no **deductible** applies
More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy**	$30, no **deductible** applies	$30, no **deductible** applies
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	$45, no **deductible** applies	$45, no **deductible** applies
More than a 60 day supply but less than a 91 day supply at a **mail order pharmacy**	$0, no **deductible** applies	$0, no **deductible** applies

Preferred prescription drugs

Description	In-network	Out-of-network
30 day supply filled at a **retail pharmacy**	$25, no **deductible** applies	$25, no **deductible** applies
More than 30 day supply but less than 61 day supply at a **retail pharmacy**	$50, no **deductible** applies	$50, no **deductible** applies
More than 60 day supply but less than 91 day supply at a **retail pharmacy**	$75, no **deductible** applies	$75, no **deductible** applies
More than 60 day supply but less than 91 day supply at a **mail order pharmacy**	$10, no **deductible** applies	$10, no **deductible** applies

Other covered services

Anti-cancer drugs taken by mouth including chemotherapy drugs

Description	In-network	Out-of-network
30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than 60 day supply but less than 91 day supply at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than 30 day supply but less than 91 day supply at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network	Out-of-network
30 day or 6 month supply of generic and OTC drugs and devices	$0, no **deductible** applies	Paid according to the type of drug per the schedule of benefits, above
30 day or 6 month supply of **brand-name prescription drugs** and devices	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

Preventive care

Description	In-network	Out-of-network
Preventive care services	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Breast-feeding support and counseling services	0% of the **negotiated charge** per visit, no **deductible** applies	0% of the **allowable amount** per visit no **deductible** applies
Breast-feeding support and counseling services limit per year	6 visits in a group or individual setting **Telemedicine** and/or **telehealth** visits do not apply toward your visit limit. All other visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting **Telemedicine** and/or **telehealth** visits do not apply toward your visit limit. All other visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	**Important note:** You are limited to 2 breast pump kits per birth • The purchase of an electric or manual breast pump, including supplies and accessories • The purchase or rental of a multi-user breast pump, including supplies and accessories	
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump	Electric pump: 3 years to replace an existing electric pump
Counseling for substance use disorder	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Counseling substance use disorder visit limit	5 visits/12 months	5 visits/12 months
Counseling for genetic risk for breast and ovarian cancer	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Counseling for genetic risk for breast and ovarian cancer visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Counseling for obesity, healthy diet visit limit	26 visits/12 months Of the total visits allowed per year, 10 may be used for high cholesterol and other known risk factors for heart disease and diet-related chronic diseases	26 visits/12 months Of the total visits allowed per year, 10 may be used for high cholesterol and other known risk factors for heart disease and diet-related chronic diseases
Counseling for sexually transmitted infection	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months

Family planning services (contraceptive counseling)	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Family planning services (contraceptive counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Prescription and OTC contraceptives (birth control)	0% of the **negotiated charge**	20% of the **allowable amount** per supply after **deductible**
Preventive care drugs and supplements	0% of the **negotiated charge,** no **deductible** applies	20% of the **allowable amount** per supply after **deductible**
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	0% of the **negotiated charge,** no **deductible** applies	20% of the **allowable amount** per supply after **deductible**
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care tobacco cessation **prescription** and OTC drugs	0% of the **negotiated charge,** no **deductible** applies	20% of the **allowable amount** per supply after **deductible**

Limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Routine cancer screenings	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Lung cancer screening	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exams	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Routine physical exams limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year 3 exams every 12 months age 1-2 3 exams every 12 months age 2-3 and 1 exam every 12 months after that age up to age 22 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year 3 exams every 12 months age 1-2 3 exams every 12 months age 2-3 and 1 exam every 12 months after that age up to age 22 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months

Well woman preventive visits	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Well woman preventive visits limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 visit	1 visit

Private duty nursing - outpatient

Up to eight hours equals one shift

Description	In-network	Out-of-network
Outpatient services	20% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Visit/shift limit per year	70	70

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	$10 per item, no **deductible** applies	20% of the **allowable amount** per item, after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term rehabilitation services

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Spinal Manipulation

Description	In-network	Out-of-network
Spinal manipulation	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Visit limit per year	30	30

Physical, occupational and speech therapies

Description	In-network	Out-of-network
PT, OT and ST	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year	90	90

Sickle cell anemia

Description	In-network	Out-of-network
Medical expenses and **prescription** drugs for treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	20% of the **allowable amount** per admission after **deductible**
Other inpatient services and supplies	0% of the **negotiated charge** per admission, no **deductible** applies	20% of the **allowable amount** per admission after **deductible**
Day limit per year	120	120

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	In-network provider (IOE facility)	In-network provider (Non-IOE facility)	Out-of-network provider
Inpatient services and supplies	0% of the **negotiated charge** per transplant, no **deductible** applies	0% of the **negotiated charge** per transplant, no **deductible** applies	20% of the **allowable amount** per transplant after **deductible**
Physician services	$10 per visit, no **deductible** applies	20% of the **negotiated charge** per visit, after **deductible**	20% of the **allowable amount** per visit after **deductible**

Transplant important note:
See the *Transplant services* benefit in the *Coverage and exclusions* section of the certificate for more information. The limit applies to all transplant services received while you are a member of an Aetna plan or one associated with us. The plan **lifetime maximum**, if any, will not apply to transplant services. The transplant limit will apply.

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Visit limit	1 visit every 12 months	1 visit every 12 months

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

Description	In-network	Out-of-network
Non-emergency services	$10 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Preventive immunizations	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Screening and counseling services	0% per visit, no **deductible** applies	20% per visit after **deductible**
Screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB

Schedule of Benefits

Prepared for:

Policyholder:	Monroe Township Board of Education
Policyholder number:	GP-152709
Plan name:	Open Access Managed Choice $20 Plan
Summary of Coverage:	2B
Group policy effective date:	July 1, 2020
Plan effective date:	July 1, 2020
Plan issue date:	May 28, 2021
Plan revision effective date:	July 1, 2021

Underwritten by Aetna Life Insurance Company in the state of New Jersey



Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles, copayments** or **coinsurance**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services.**
- **Coinsurance** amounts, if any, listed in the schedule below are what the plan will pay for **covered services.** Sometimes for out-of-network services, your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **coinsurance** percentage that your plan will pay. You are responsible to pay any **deductibles, copayments** and remaining **coinsurance**, if they apply and before the plan will pay for any **covered services.**
- When a **covered service** shows "no charge", this means you have no responsibility for **deductibles, copayments** or **coinsurance.**
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service.**
- This plan has limits for some **covered services.** For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between in-**network** and **out-of-network providers**
  - Separate limits for in-**network** and **out-of-network providers**
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

  See the schedule of benefits for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

Important note:
Covered services are subject to the Calendar Year **deductible, maximum out-of-pocket,** limits, **copayment** or **coinsurance** unless otherwise stated in this schedule of benefits.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **coinsurance** you pay when you get **covered services** from an in-**network, out-of-network provider.** This schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services.** You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible.**

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP.**

How your maximum out-of-pocket works

This schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your certificate.

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features

Precertification covered services reduction

This only applies to **out-of-network covered services:**
Your certificate contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

If **precertification** for **covered services** isn't completed, when required, it can result in any of the following benefit reductions:

- **Covered services** reduced by the lesser of 50% of the benefit that would have been payable or $400. The reduction will not exceed 50% of the charges which would otherwise be covered under the plan.

You may have to pay an additional portion of the **allowable amount** because you didn't get **precertification.** This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit,** if you have one.

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network	Out-of-network
Individual	$0 per year	$500 per year
Family	$0 per year	$1,000 per year

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$3,000 per year	$3,000 per year
Family	$6,000 per year	$6,000 per year

Outpatient prescription drug maximum out-of-pocket limit

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$3,000 per year	$3,000 per year
Family	$6,000 per year	$6,000 per year

General coverage provisions

This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

Out-of-network **covered services** will apply only to the out-of-network **deductible**.

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **coinsurance**, if any, for these **covered services**.

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Deductible credit

If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Copayment

This is a dollar amount you pay for a **covered service**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**.

Coinsurance

This is a percentage you pay for a **covered service**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit provisions

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **deductibles, copayments**, and **coinsurance**, if any, for **covered services**.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services which are identified in the certificate and the schedule
- Charges, expenses or costs in excess of the **allowable amount**
- Costs for non-emergency use of the emergency room

Limit provisions – maximum out of pocket

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group policy.

Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share and **deductible** you have paid during the year for **covered services** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that apply toward the limit for you for the remainder of the year.

Family prescription drug maximum out-of-pocket limit

After the amount of the cost share you and your covered dependent pay for **covered services** during the year meets the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

This plan has an individual and family **prescription** drug **maximum out-of-pocket limit**

The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **prescription** drug **maximum out-of-pocket limit** is met by a combination of family members with no single person in the family contributing more than the individual **maximum out-of-pocket limit** in a year.

The **maximum out-of-pocket limit** may not apply to certain **covered services**. If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit**.

All costs for non-covered services do not apply toward the **maximum out-of-pocket limit**.

Covered services

Description	In-network	Out-of-network
Acupuncture	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Ambulance services

Description	In-network	Out-of-network
Emergency services	0% of the **negotiated charge** per trip, no **deductible** applies	30% of the **allowable amount** per trip after **deductible**
Non-emergency services	0% of the **negotiated charge** per trip, no **deductible** applies	30% of the **allowable amount** per trip after **deductible**

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Clinical trials

Description	In-network	Out-of-network
Experimental and investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Dental care anesthesia

Description	In-network	Out-of-network
Hospital charges	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Diabetic services, supplies, equipment, and self-care programs

Description	In-network	Out-of-network
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	0% of the **negotiated charge** per item, no **deductible** applies	30% of the **allowable amount** per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$100 per visit, no **deductible** applies	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note:
Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** as an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Foot orthotic devices

Description	In-network	Out-of-network
Orthotic devices	$20 per visit, no **deductible** applies	30% of the **allowable amount** per item after **deductible**

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network	Out-of-network
PT, OT therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Speech therapy

Description	In-network	Out-of-network
Speech therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing aids

Description	In-network	Out-of-network
Hearing aids	$20 per visit, no **deductible** applies	30% of the **allowable amount** per item after **deductible**
Age limit	Covered persons through age 15	Covered persons through age 15
Frequency limit	One per ear every 24 months	One per ear every 24 months
Benefit limit	$1,000	$1,000

Hearing exams

Description	In-network	Out-of-network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Visit limit per day	3 visits	3 visits
Visit limit per year	Unlimited	100

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

Home hemophilia treatment

Description	In-network	Out-of-network
Home treatments	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	30% of the **allowable amount** per admission after **deductible**
Outpatient services	0% of the **negotiated charge** per visit, no **deductible applies**	30% of the **allowable amount** per visit, after **deductible**
Visit limit per year	unlimited	unlimited

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

Hospital care

Description	In-network	Out-of-network
Inpatient services - **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	30% of the **allowable amount** per admission after **deductible**

Infertility services

Description	In-network	Out-of-network
Treatment of **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Advanced reproductive technology (ART)

For this benefit, lifetime means any covered benefits paid under this plan, another plan with Aetna or plan associated with us, with the same policyholder.

Description	In-network	Out-of-network
	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	30% of the **allowable amount** per admission after **deductible**
Services performed in **physician** office or a facility	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Services performed in **specialist** office or a facility	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Other services and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Maternity and related newborn care important note: Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.		

Mental health conditions

Mental health treatment

Coverage provided under the **same terms and conditions** as for any other condition

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	0% of the **negotiated charge** per admission, no **deductible** applies	30% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** and/or **telehealth** consultation	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Outpatient mental health **telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Autism spectrum disorder or other developmental disabilities

Description	In-network	Out-of-network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Outpatient occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Substance use disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided under the **same terms and conditions** as for any other condition

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	0% of the **negotiated charge** per admission, no **deductible** applies	30% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** and/or **telehealth** consultation	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Outpatient **telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Nutritional support

Description	In-network	Out-of-network
Nutritional support	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	30% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Physician services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not surgical, not preventive) Includes **telemedicine** and/or **telehealth** consultation	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Physician home visit (not preventive)	0% of the **negotiated charge** per visit no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Physician surgical services	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine and/or **telehealth** consultation	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit, after **deductible**

Physician Services-Specialist

Description	In-network	Out-of-network
Specialist office hours (not surgical, not preventive)	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Specialist home visit (not preventive)	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Specialist surgical services	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine and/or **telehealth** consultation	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Physician services -all other services not shown above

Description	In-network	Out-of-network
All other services	Covered based on type of service and where it is received.	Covered based on type of service and where it is received.

Prescription drugs – outpatient

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply filled at a **retail pharmacy**	$15, no **deductible** applies	$15, no **deductible** applies
More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy**	$30, no **deductible** applies	$30, no **deductible** applies
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	$45, no **deductible** applies	$45, no **deductible** applies
More than a 60 day supply but less than a 91 day supply at a **mail order pharmacy**	$0, no **deductible** applies	$0, no **deductible** applies

Preferred prescription drugs

Description	In-network	Out-of-network
30 day supply filled at a **retail pharmacy**	$25, no **deductible** applies	$25, no **deductible** applies
More than 30 day supply but less than 61 day supply at a **retail pharmacy**	$50, no **deductible** applies	$50, no **deductible** applies
More than 60 day supply but less than 91 day supply at a **retail pharmacy**	$75, no **deductible** applies	$75, no **deductible** applies
More than 60 day supply but less than 91 day supply at a **mail order pharmacy**	$10, no **deductible** applies	$10, no **deductible** applies

Other covered services

Anti-cancer drugs taken by mouth including chemotherapy drugs

Description	In-network	Out-of-network
30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than 60 day supply but less than 91 day supply at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than 30 day supply but less than 91 day supply at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network	Out-of-network
30 day or 6 month supply of generic and OTC drugs and devices	$0, no **deductible** applies	Paid according to the type of drug per the schedule of benefits, above
30 day or 6 month supply of **brand-name prescription drugs** and devices	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Paid according to the type of drug per the schedule of benefits, above
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

Preventive care

Description	In-network	Out-of-network
Preventive care services	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Breast-feeding support and counseling services	0% of the **negotiated charge** per visit, no **deductible** applies	0% of the **allowable amount** per visit no **deductible** applies
Breast-feeding support and counseling services limit per year	6 visits in a group or individual setting **Telemedicine** and/or **telehealth** visits do not apply toward your visit limit. All other visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting **Telemedicine** and/or **telehealth** visits do not apply toward your visit limit. All other visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	**Important note:** You are limited to 2 breast pump kits per birth • The purchase of an electric or manual breast pump, including supplies and accessories • The purchase or rental of a multi-user breast pump, including supplies and accessories	
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump	Electric pump: 3 years to replace an existing electric pump
Counseling for substance use disorder	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Counseling substance use disorder visit limit	5 visits/12 months	5 visits/12 months
Counseling for genetic risk for breast and ovarian cancer	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Counseling for genetic risk for breast and ovarian cancer visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Counseling for obesity, healthy diet visit limit	26 visits/12 months Of the total visits allowed per year, 10 may be used for high cholesterol and other known risk factors for heart disease and diet-related chronic diseases	26 visits/12 months Of the total visits allowed per year, 10 may be used for high cholesterol and other known risk factors for heart disease and diet-related chronic diseases
Counseling for sexually transmitted infection	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months

Family planning services (contraceptive counseling)	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Family planning services (contraceptive counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Prescription and OTC contraceptives (birth control)	0% of the **negotiated charge**	30% of the **allowable amount** per supply after **deductible**
Preventive care drugs and supplements	0% of the **negotiated charge,** no **deductible** applies	30% of the **allowable amount** per supply after **deductible** applies
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	0% of the **negotiated charge,** no **deductible** applies	30% of the **allowable amount** per supply after **deductible**
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care tobacco cessation **prescription** and OTC drugs	0% of the **negotiated charge,** no **deductible** applies	30% of the **allowable amount** per supply after **deductible**

Limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Routine cancer screenings	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Lung cancer screening	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exams	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Routine physical exams limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year 3 exams every 12 months age 1-2 3 exams every 12 months age 2-3 and 1 exam every 12 months after that age up to age 22 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year 3 exams every 12 months age 1-2 3 exams every 12 months age 2-3 and 1 exam every 12 months after that age up to age 22 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months

Well woman preventive visits	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Well woman preventive visits limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 visit	1 visit

Private duty nursing - outpatient

Up to eight hours equals one shift

Description	In-network	Out-of-network
Outpatient services	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Visit/shift limit per year	70	70

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	$20 per item, no **deductible** applies	30% of the **allowable amount** per item, after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term rehabilitation services

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Spinal Manipulation

Description	In-network	Out-of-network
Spinal manipulation	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Visit limit per year	25	25

Physical, occupational and speech therapies

Description	In-network	Out-of-network
PT, OT and ST	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year	90	90

Sickle cell anemia

Description	In-network	Out-of-network
Medical expenses and **prescription** drugs for treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	0% of the **negotiated charge** per admission, no **deductible** applies	30% of the **allowable amount** per admission after **deductible**
Other inpatient services and supplies	0% of the **negotiated charge** per admission, no **deductible** applies	30% of the **allowable amount** per admission after **deductible**

Day limit per year	100	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	In-network provider (IOE facility)	In-network provider (Non-IOE facility)	Out-of-network provider
Inpatient services and supplies	0% of the **negotiated charge** per transplant, no **deductible** applies	0% of the **negotiated charge** per transplant, no **deductible** applies	30% of the **allowable amount** per transplant after **deductible**
Physician services	$20 per visit, no **deductible** applies	30% of the **negotiated charge** per visit, after **deductible**	30% of the **allowable amount** per visit after **deductible**

Transplant important note:
See the *Transplant services* benefit in the *Coverage and exclusions* section of the certificate for more information. The limit applies to all transplant services received while you are a member of an Aetna plan or one associated with us. The plan **lifetime maximum**, if any, will not apply to transplant services. The transplant limit will apply.

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**

Visit limit	1 visit every 12 months	1 visit every 12 months

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

Description	In-network	Out-of-network
Non-emergency services	$20 per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Preventive immunizations	0% of the **negotiated charge** per visit, no **deductible** applies	30% of the **allowable amount** per visit after **deductible**
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Screening and counseling services	0% per visit, no **deductible** applies	30% per visit after **deductible**
Screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB