PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	None Individual None Family	$350 Individual $700 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance	Covered 100%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$500 Individual $1,000 Family	$2,000 Individual $5,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 200% of Medicare Facility: 200% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%	Not Covered
1 exam every year up to age 65, 1 exam every year age 65 and older		
Routine Well Child Exams	Covered 100%	Not Covered Immunizations covered at 30%; after deductible for children under 12 months
7 exams the first year, 3 exams the second year, 3 exams the third year, 1 exam per year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%	30%; after deductible
1 obgyn exam and pap smear per year		

PLAN DESIGN & BENEFITS
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Routine Mammograms	Covered 100%	30%; after deductible
Women's Health	Covered 100%	30%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%	Not Covered
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%	Not Covered
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%	Not Covered
Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.		
Routine Eye Exams	$15 copay	Not Covered
1 routine exam per year. Includes glaucoma test every 5 years for all covered members age 35 and over.		
Newborn Hearing Testing and Monitoring	$15 copay	Not Covered
Routine Hearing Screening	Covered 100%	Not Covered
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$10 office visit copay	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$15 office visit copay	30%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	$15 office visit copay	30%; after deductible
Walk-in Clinics	$15 copay	30%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Covered 100%	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	Covered 100%	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Outpatient Complex Imaging	Covered 100%	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$15 office visit copay	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$125 copay	Same as in-network care
Copay waived if admitted		

PLAN DESIGN & BENEFITS
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Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%	30%; after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$15 copay	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%	30%; after deductible
Substance Abuse Office Visits	$15 copay	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered 100% Limited to 120 days per year	30%; after deductible Limited to 60 days per year
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%	30%; after deductible
Private Duty Nursing not included.		
Hospice Care - Inpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay. Respite care maximum 10 days per 6 months.		
Hospice Care - Outpatient	Covered 100%	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	10%	30%; after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Spinal Manipulation Therapy Limited to 30 visits per year	$15 copay	Lesser of $35/visit or 75% of in-network cost/visit

PLAN DESIGN & BENEFITS
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Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy	$15 copay	30%; after deductible for speech and occupational therapy Lesser of $52/visit or 75% of in-network cost/visit for physical therapy only
Habilitative Physical Therapy	$15 copay	30%; after deductible
Habilitative Occupational Therapy	$15 copay	30%; after deductible
Habilitative Speech Therapy	$15 copay	30%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$15 copay	30%; after deductible
Autism Occupational Therapy	$15 copay	30%; after deductible
Autism Speech Therapy	$15 copay	30%; after deductible
Hearing Aids Coverage for all persons age 15 or younger. One hearing aid for each impaired ear limited to $1,000 per hearing aid every 24 months.	$10 copay	30%; after deductible
Durable Medical Equipment	10%	30%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	10%	30%; after deductible
Prosthetics	$15 copay	30%; after deductible
Orthotics	$15 copay	30%; after deductible
Fertility Drugs (oral and injectable) Physician charges included (oral and injectable fertility drugs obtained at a pharmacy are covered under the Rx plan).	Covered 100%	30%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	$15 copay	30%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Acupuncture	$15 copay	Lesser of $60/visit or 75% of in-network cost/visit
Transplants	Covered 100% Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%	30%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	$15 copay	30%; after deductible
Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Advanced Reproductive Technology (ART)	$15 copay	30%; after deductible
ART coverage includes In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 egg retrievals per lifetime. Coverage includes cryopreservation for iatrogenic infertility.		
Vasectomy	Covered 100%	30%; after deductible
Tubal Ligation	Covered 100%	30%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	New Jersey Educators Health Plan Formulary	
Generic Drugs		
Retail	$5 copay	Copay + amount above the Allowed Amount
Mail Order	$10 copay	Copay + amount above the Allowed Amount
Preferred Brand-Name Drugs		
Retail	$10 copay	Copay + amount above the Allowed Amount
Mail Order	$20 copay	Copay + amount above the Allowed Amount
Non-Preferred Brand-Name Drugs		
Retail	$10 copay	Copay + amount above the Allowed Amount
Mail Order	$20 copay	Copay + amount above the Allowed Amount
Specialty Drugs		
Preferred Specialty	$20 copay	Not Covered
Non-Preferred Specialty	$20 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	All prescription fills must be through our preferred specialty pharmacy network.	
Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay only, if the physician requires brand-name. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited). Oral chemotherapy drugs covered 100% Precertification and quantity limits included Step Therapy included		

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Prescription Drug Annual Out of Pocket Maximum	$1,600 Individual $3,200 Family	Not Applicable
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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

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

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

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

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

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

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See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

PLAN DESIGN & BENEFITS
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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions.
CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.