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Morris Hills Regional District Board of Education
Effective Date: 07-01-2016
Managed Choice ® POS - New Jersey

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None Individual None Family	$100 Individual $250 Family

Unless otherwise indicated, the deductible must be met prior to benefits being payable.
Member costs sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.
The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.

Payment Limit (per calendar year)	$2,000 Individual $4,000 Family	$2,100 Individual $5,250 Family

Certain member cost sharing elements may not apply toward the Payment Limit.
Pharmacy expenses apply towards the Payment Limit.
Only those out-of-pocket expenses resulting from the application of coinsurance percentage 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.
Unlimited except where otherwise indicated.

Primary Care Physician Selection	Required	Not Applicable
Referrals	Required	Not Applicable
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every calendar year	Covered 100%	30%; deductible waived
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.	Covered 100%	30%; deductible waived
Routine Gynecological Care Exams Includes routine tests and related lab fees. 1 exam per calendar year Direct access to participating providers without a referral.	Covered 100%	30%; deductible waived
Routine Mammograms Recommended: One baseline mammogram for covered females age 35-39, no frequency limit for routine mammograms for covered females age 40 and over.	Covered 100%	30%; deductible waived
Women's Health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	30%; deductible waived
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%	30%; deductible waived
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%	30%; deductible waived
Colorectal Cancer Screening Recommended: For all members age 50 and over. Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.	Covered 100%	30%; deductible waived
Routine Eye Exams	Not Covered	

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Routine Hearing Screening	Covered 100%	30%; deductible waived
Newborn Hearing Testing and Monitoring	$10 copay	30%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$10 copay	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$10 copay	30%; after deductible
Pre-Natal Maternity (Initial Visit $10 Copay)	Covered 100%	30%; after deductible
Walk-in Clinics	$10 office visit copay	30%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	$10 office visit copay	30%; after deductible
Allergy Injections	Covered 100% when an office visit charge is not applicable.	30%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	Covered 100%	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Outpatient Complex Imaging	Covered 100%	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$10 copay	$10 copay ; deductible waived
Non-Urgent Use of Urgent Care Provider	$10 copay	30%; after deductible
Emergency Room Copay waived if admitted	$50 copay	$50 copay
Emergency Use of Ambulance	Covered 100%	Covered 100%
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%	30%; after deductible

The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

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MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$10 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	Covered 100%	30%; after deductible
Outpatient	$10 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	Covered 100%	30%; after deductible
Limited to 120 days per calendar year In-Network. 60 days Out of Network The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100%	30%; after deductible
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Short-Term Rehabilitation	$10 copay	30%; after deductible
Autism Behavioral Therapy	Covered same as any other Outpatient OV	30%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	Covered same as any other Outpatient OV	30%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Physical Therapy	$10 copay	30%; after deductible
Autism Physical Therapy, Autism Occupational Therapy, and Autism Speech Therapy is equal to the same number of visits provided for Short Term Rehabilitation		
Autism Occupational Therapy	$10 copay	30%; after deductible
Autism Physical Therapy, Autism Occupational Therapy, and Autism Speech Therapy is equal to the same number of visits provided for Short Term Rehabilitation		
Autism Speech Therapy	$10 copay	30%; after deductible
Autism Physical Therapy, Autism Occupational Therapy, and Autism Speech Therapy is equal to the same number of visits provided for Short Term Rehabilitation		
Spinal Manipulation Therapy 25 visit maximum combined in and out of network	$10 copay	30%; after deductible
Hearing Aids	Covered 100%	30%; after deductible
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.		
Durable Medical Equipment	Covered 100%	30%; after deductible
Prosthetics	$10 copay	30%; after deductible
Generic FDA-approved Women's Contraceptives	Covered 100%	30%; after deductible

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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.
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	$10 copay	30%; after deductible
Diagnosis and treatment of the underlying medical condition. Coverage includes Artificial Insemination and Ovulation Induction.		
Vasectomy	Covered 100%	30%; after deductible
Tubal Ligation	Covered 100%	30%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Generic Drugs		
Retail	$5 copay	$5 copay
Mail Order	$15 copay	
Brand-Name Drugs		
Retail	$15 copay	$15 copay
Mail Order	$45 copay	
Pharmacy Day Supply and Requirements		
Retail	Up to a 34 day supply	
Mail Order	Up to a 90 day supply from Aetna Rx Home Delivery®.	
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 (end of the month) regardless of student status.	

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

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

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

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

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- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Home births
- Immunizations for travel or work, except where medically necessary or indicated..
- 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 or inadequacies, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

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.**