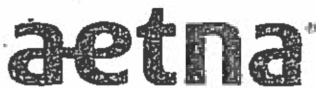


Morris Hill Regional District Board of Education
Effective Date: 07-01-2016
Passive PPO - New Jersey

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$200 Individual $400 Family	$200 Individual $400 Family

All covered expenses cross apply toward the preferred or non-preferred Deductible.
Unless otherwise indicated, the deductible must be met prior to benefits being payable.
Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.
Pharmacy expenses 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.

Payment Limit (per calendar year)	$600 Individual $1,200 Family	$600 Individual $1,200 Family

All covered expenses cross apply toward the preferred or non-preferred Payment Limit.
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, 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.
Unlimited except where otherwise indicated.

PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	Covered 100%; deductible waived

1 exam per calendar year

Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	Covered 100%; deductible waived

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.

Routine Gynecological Care Exams	Covered 100%; deductible waived	Covered 100%; deductible waived

Includes routine tests and related lab fees.

Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	Covered 100%; deductible waived

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.

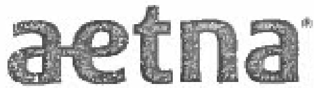
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	Covered 100%; deductible waived
Prostate-specific Antigen Test	Covered 100%; deductible waived	Covered 100%; deductible waived

Recommended: For covered males age 40 and over.

Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived

Recommended: For all members age 50 and over. Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.

Routine Hearing Screening	Covered 100%; deductible waived	Covered 100%; deductible waived



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PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to non-Specialist	20%; after deductible	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	20%; after deductible	20%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
Walk-in Clinics	20%; after deductible	20%; 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	20%; after deductible	20%; after deductible
Allergy Injections	20%; after deductible	20%; after deductible

DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	Covered 100%; deductible waived	Covered 100%; deductible waived
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%; deductible waived	Covered 100%; deductible waived
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%; deductible waived	Covered 100%; deductible waived

EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	Covered 100%; deductible waived	Covered 100%; deductible waived
Non-Urgent Use of Urgent Care Provider	20%; after deductible	20%; after deductible
Emergency Room	Covered 100%; deductible waived	Covered 100%; deductible waived
Emergency Use of Ambulance	20%; after deductible	Same as in-network care

HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	Covered 100%; deductible waived	Covered 100%; deductible waived
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%; deductible waived	Covered 100%; deductible waived
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; deductible waived	Covered 100%; deductible waived
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%; deductible waived	Covered 100%; deductible waived
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%; deductible waived	Covered 100%; deductible waived
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	Covered 100%; deductible waived
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	20%; after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

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ALCOHOL/DRUG ABUSE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%; deductible waived	Covered 100%; deductible waived
Residential Treatment Facility	Covered 100%; deductible waived	Covered 100%; deductible waived
Outpatient	20% after deductible	20% after deductible

OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Convalescent Facility This benefit includes a combination of other Inpatient Services at Other Health Care Facilities.	Covered 100%; deductible waived	Covered 100%; deductible waived
Home Health Care 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.	Covered 100%; deductible waived	Covered 100%; deductible waived
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%; deductible waived	Covered 100%; deductible waived
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%; deductible waived	Covered 100%; deductible waived
Short Term Rehabilitative Therapy: Includes speech, physical, occupational therapy	20% after deductible	20% after deductible
Spinal Manipulation Therapy 60 visit maximum	20% after deductible	20% after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	20% after deductible	20% after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health benefit	Covered at 100%; deductible waived	Covered 100%; deductible waived
Autism Physical Therapy	20% after deductible	20% after deductible
Autism Occupational Therapy	20% after deductible	20% after deductible
Autism Speech Therapy	20% after deductible	20% after deductible
Durable Medical Equipment	20% after deductible	20% after deductible
Prosthetics	20% after deductible	20% after deductible
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	20% after deductible
Hearing Aids 1 hearing aid per ear to $1,000 maximum per ear every 24 months for child to age 16.	20% after deductible	20% after deductible
Transplants The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%; deductible waived Preferred coverage is provided at an IOE contracted facility only.	Covered 100%; deductible waived Non-Preferred coverage is provided at a Non-IOE facility.
"Other" Health Care -- 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred".		

FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	20%; after deductible	20%; after deductible

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Coverage includes Artificial Insemination and Ovulation Induction.

Vasectomy	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%; deductible waived	Covered 100%; deductible waived
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type		
Generic Drugs		
Retail	20%; after deductible	20%; after deductible
Mail Order	20%	
Brand-Name Drugs		
Retail	20%; after deductible	20%; after deductible
Mail Order	20%	
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply	
Mail Order	Up to a 90 day supply from Aetna Rx Home Delivery®.	
Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network.	

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).

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 (end of month) 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.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

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This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

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.

- 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.
- 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.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.