



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetna.com/sbcsearch/getpolicydocs?u=082900-030020-002221> or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0. Out-of-Network: Individual \$350 / Family \$700.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Emergency care & <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual \$500 / Family \$1,000. Out-of-Network: Individual \$2,000 / Family \$5,000. <u>Prescription drugs</u> : Individual \$1,600 / Family \$3,200.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See http://www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered, except 30% <u>coinsurance</u> for mammograms & gynecological exams; <u>deductible</u> doesn't apply to child immunizations	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition Prescription drug coverage is administered by New Jersey Educators Health Plan Formulary More information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$5 for 30 day supply, \$10 for 60 day supply, \$15 for 90 day supply (retail), \$10 for 31-90 day supply (mail order)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$5 for 30 day supply, \$10 for 60 day supply, \$15 for 90 day supply (retail), \$10 for 31-90 day supply (mail order)	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$10 for 30 day supply, \$20 for 60 day supply, \$30 for 90 day supply (retail), \$20 for 31-90 day supply (mail order)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$10 for 30 day supply, \$20 for 60 day supply, \$30 for 90 day supply (retail), \$20 for 31-90 day supply (mail order)	
	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$10 for 30 day supply, \$20	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$10 for 30 day	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		for 60 day supply, \$30 for 90 day supply (retail), \$20 for 31-90 day supply (mail order)	supply, \$20 for 60 day supply, \$30 for 90 day supply (retail), \$20 for 31-90 day supply (mail order)	
	<u>Specialty drugs</u>	<u>Copay/prescription, deductible</u> doesn't apply: \$20	<u>Copay/prescription, deductible</u> doesn't apply: \$20	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$125 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$125 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except 30% <u>coinsurance</u> if pre-authorized.
	<u>Urgent care</u>	\$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	No charge	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge; except \$15 <u>copay</u> for initial visit to confirm pregnancy, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> required for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Out-of-network maximum: 75% of in-network cost up to \$52/visit for Physical Therapy.
	<u>Habilitation services</u>	No charge	30% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	120 days/calendar year in-network & 60 days out-of-network/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	1 routine eye exam/calendar year.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-------------------------------|--|---|
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult & Child) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs - Except for required <u>preventive services</u> . |
| • Glasses (Child) | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - Limited to disease, injury & chronic pain. Out-of-network maximum: 75% of in-network cost up to \$60/visit.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year. Out-of-network maximum: 75% of in-network cost up to 35/visit
- Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months for children up to age 16.
- Infertility treatment - For more information & exceptions, see policy document using summary box link on page 1 or call the number on your ID card.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/calendar year for in-network only.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Toll-free phone: 1-888-393-1062, In-State Only, or Consumer Hotline: 1-800-446-7467, https://www.state.nj.us/dobi/division_insurance/managedcare/mcfaqs.htm.

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Toll-free phone: 1-888-393-1062, In-State Only, or Consumer Hotline: 1-800-446-7467, https://www.state.nj.us/dobi/division_insurance/managedcare/mcfaqs.htm.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact The Office of the Insurance Ombudsman, NJ Department of Banking and Insurance, 20 West State Street, PO Box 472, Trenton, NJ 08625-0472, 1-800-446-7467, Fax: 609-292-2431, <http://www.state.nj.us/dobi/consumer.htm>, ombudsman@dobi.state.nj.us

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$0
- Other copayment \$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$0
- Other copayment \$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
 Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$0
- Other copayment \$0

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$290

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

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, disability, gender identity or sexual orientation.

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 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).

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Supplemental Information

Coverage for: Individual + Family | Plan Type: POS

How is the overall <u>deductible</u> or <u>out-of-pocket limit</u> met?	Individual <u>deductible</u> and <u>out-of-pocket limit</u> payments apply to the family <u>deductible</u> and <u>out-of-pocket limit</u> .	The family <u>deductible</u> and family <u>out-of-pocket limit</u> are cumulative for all family members. The family <u>deductible</u> and <u>out-of-pocket limit</u> can be met by a combination of family members; however no single individual within the family will be subject to more than the individual <u>deductible</u> or <u>out-of-pocket limit</u> amount.
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How your out-of-network care is reimbursed:

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 Aetna pays 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 Aetna 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, Aetna limits the amount it will pay. This limit is called the "recognized" or "**allowed**" **amount**.

Professional Services: 200% of Medicare

Facility Services: 200% of Medicare

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna **plan** "recognizes." Your doctor may bill you for the dollar amount that your **plan** doesn'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 limit**. To learn more about how we pay out-of-network benefits, visit www.aetna.com. Type “how Aetna pays” in the search box.

You can avoid these extra costs by getting your care from Aetna’s **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 Aetna 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 Aetna if your health care **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**.

Other important information about your plan:

This **plan** does not cover all health care expenses and includes exclusions and limitations. Members should refer to their **plan** documents to determine which

Supplemental Information

Coverage for: Individual + Family | Plan Type: POS

health care services are covered and to what extent.

Additional information regarding your **plan** is available in the Disclosure Document on www.aetna.com.

Information includes:

- “Knowing what is covered” which describes how we review a request for coverage for a service or supply
- “**Prescription drug** benefit” which describes procedures we use to manage **prescription drug** benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

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 agents of Aetna. **Provider** participation may change without notice. We do not provide care or guarantee access to health services.

The following is a partial 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 you or your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- 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 with respect to the treatment of cancer or other life-threatening disease or condition
- Home births
- Immunizations for travel or work except where **medically necessary** or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy
- Non-**medically necessary** services or supplies
- Orthotics except diabetic orthotics
- 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, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

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Supplemental Information

Coverage for: Individual + Family | **Plan Type:** POS

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

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

Plan features and availability may vary by location and group size.

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