SUMMARY OF MEDICAL BENEFITS

Aetna HNO $20/$40 (Actives) PCP Selection Not Required	NETWORK PROVIDERS Based on Contracted Fees	NON-NETWORK PROVIDERS Based on the Allowed Amount
DEDUCTIBLE PER CALENDAR YEAR		
Per Covered Person	$1,750	N/A
Per Family Unit	$3,500 - Family Plan enrollment: No benefits will be paid prior to meeting full family deductible	N/A
No deductible carryover applies from previous benefit period.		
PRECERTIFICATION REQUIREMENT		
Plan requires precertification of Medical Necessity for certain services before Medical and/or Surgical services are provided. Please see the Cost Management section of this booklet for more details. Failure to follow precertification procedures may reduce benefit payment by the plan. Contact your claims adminstrator for any applicable penalty amounts.		
SECOND AND/OR THIRD OPINION PROGRAM REQUIREMENT		
Second and/or third opinion program is encouraged but not required by this Plan. Please see the Cost Management section of this booklet for more details.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$3,500	N/A
Per Family Unit	$7,000	N/A
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the Maximum Out-of-pocket Amount and are never paid at 100%: - Cost containment penalties, Charges over the Allowed Amount, Non-covered charges All In-Network Out-of-pocket expenses for covered charges will accumulate to satisfy the In-Network Maximum Out-of-pocket amount. All Non-Network Out-of-pocket expenses for covered charges will accumulate to satisfy the Non-Network Maximum Out-of-pocket amount.		
COVERED CHARGES		
Hospital Services		
Inpatient	Subject to deductible; $250 copay/stay	Not Covered
Intensive Care Unit	Subject to deductible; $250 copay/stay	Not Covered
Emergency Room Visit - Payment at the In-Network level applies only to true Medical emergencies and Accidental Injuries.		
Medical Emergency	Subject to deductible; $100 copayment	Subject to deductible; $100 copayment
Urgent Care	Subject to deductible; $40 copayment	Not Covered
Skilled Nursing Facility	Subject to deductible; 100% covered	Not Covered
Benefit Maximum	100 day maximum/calendar year	
Physician Services		
Inpatient visits	Subject to deductible; 100% covered	Not Covered
Office visits	Subject to deductible; $20 copayment	Not Covered
Specialist visits	Subject to deductible; $40 copayment	Not Covered
Maternity OB Visits	Subject to deductible; $40 copayment applies to first visit only	Not Covered
Surgery	Subject to deductible; $100 copayment applies to Outpatient Surgery	Not Covered
Allergy Testing	Based on Place of Service	Not Covered
Allergy Treatment	Based on Place of Service	Not Covered
Diagnostic Testing (X-ray & Lab)	Subject to deductible; 100% covered	Not Covered

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Home Health Care	Subject to deductible; 100% covered	Not covered
Inpatient Prescription Drugs	Refer to Hospital Services - Inpatient	Not Covered
Retail - Prescription Drugs	Refer to your Freestanding Prescription Plan	Not Covered
Outpatient Private Duty Nursing	Subject to deductible - limited to 30 visits/calendar year (8-hr shifts)	Not Covered
Hospice Care Contact your claims administrator for any limitations that may apply	Subject to deductible; 100% covered	Not Covered
Ambulance	Emergency Transport - No Charge after deductible; Non-Emergent Transport - Not Covered unless pre-authorized	Emergency Transport - No Charge after deductible; Non-Emergent Transport - Not Covered unless pre-authorized
Jaw Joint/TMJ	Based on Place and Type of Sevice	Not Covered
Wig After Chemotherapy	Subject to deductible; 100% covered	Not Covered
Benefit Limit	$500 benefit maximum per 24-month period	
Occupational Therapy*	Subject to deductible; $20 copayment - limited to 30 visits/calendar year	Not Covered
Speech Therapy*	Subject to deductible; $20 copayment - limited to 30 visits/calendar year	Not Covered
Physical Therapy*	Subject to deductible; $20 copayment - limited to 30 visits/calendar year	Not Covered
Benefit Limit	Based on medical necessity	
Refer to "Autism or Another Developmental Disability"in the Covered Charges section for information specific to therapy coverage associated with a diagnosis of Autism.		
Durable Medical Equipment	Subject to deductible; 100% covered	Not Covered
Vision Eyewear	Not Covered	Not Covered
Hearing Aid Devices	Subject to deductible; 100% covered	Not Covered
Benefit Limit	Coverage for persons age 15 or younger. One hearing aid for each impaired ear/24 months.	
Prosthetics	Subject to deductible; $20 copayment	Not Covered
Orthotics	Subject to deductible; $20 copayment	Not Covered
Spinal Manipulation Chiropractic	Subject to deductible; $20 copayment	Not Covered
Benefit Limit	Limited to 25 visits/calendar year	
Mental Disorders		
Inpatient	Refer to Hospital Services - Inpatient	Not Covered
Outpatient	Subject to deductible (Office - $40 copayment; Outpatient Services - 100% covered)	Not Covered
Substance Abuse		
Inpatient	Refer to Hospital Services - Inpatient	Not Covered
Outpatient	Subject to deductible (Office - $40 copayment; Outpatient Services - 100% covered)	Not Covered
Preventive Care		
Routine Well Adult Care	100% covered	Not Covered
Eligible coverage for the following listed services are subject to gender, age and frequency guidelines as well as associated risk factors. Includes: office visit for routine physical examination including counseling for obesity, alcohol and/or tobacco use, colonoscopies and services for pap smear, mammogram, prostate screening, gynecological exam, screening for blood pressure, cholesterol, type 2 diabetes, HIV, immunizations/flu shots. Refer to healthcare.gov for complete listing.		
Routine Gynecological Exam	100% covered	Not Covered

Aetna HNO $20/$40 (Actives) **PCP Selection Not Required**	**NETWORK PROVIDERS** **Based on Contracted Fees**	**NON-NETWORK PROVIDERS** **Based on the Allowed Amount**
Routine Mammograms	100% covered	Not Covered
Routine Well Newborn & Child Care	100% covered	Not Covered
Eligible coverage for the following listed services are subject to gender, age and frequency guidelines as well as associated risk factors. Includes: office visit for routine physical examination including counseling for obesity, alcohol and/or drug use, screening for autism, blood pressure, congenital hypothyroidism, developmental, hearing, lead, and vision, immunizations/flu shots, behavioral assessment. Refer to healthcare.gov for complete listing.		
Eye Exam Frequency limits may apply	Subject to deductible; $20 copayment	Not Covered
Organ Transplants	Refer to Associated Medical Service - Contact your Claims Administrator	Refer to Associated Medical Service - Contact your Claims Administrator
Infertility Benefits	Refer to Associated Medical Service	Not Covered
Benefit Limitations	*Coverage subject to current New Jersey State Mandate. Treatment covered with limitations. Contact your Claims Adminstrator for more details*	