KIPP TEAM AND FAMILY SCHOOLS, INC.
Effective Date: 07-01-2023
Open Access® Managed Choice® POS - New Jersey
Qualified High Deductible Health Plan

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 the effective date of the plan unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per plan year)	$1,500 Individual $3,000 Family	$1,750 Individual $3,500 Family
All covered expenses accumulate separately toward the in-network and out-of-network 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. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the contract year. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	20%
Payment Limit (per plan year)	$2,100 Individual $4,200 Family	$2,550 Individual $5,100 Family
All covered expenses accumulate separately toward the in-network or out-of-network 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. There is no Individual Payment Limit to satisfy within the Family Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 300% of Medicare Facility: 300% 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 or 50% of the scheduled benefit amount per occurrence, whichever is less.		
Referral Requirement	None	None
Telemedicine Consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com/ to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	20%; after deductible
Routine Well Child Exams 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	20%; after deductible
Childhood Immunizations	Covered 100%; deductible waived	20%; deductible waived
Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	Covered 100%; deductible waived	20%; after deductible

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Routine Mammograms	Covered 100%; deductible waived	20%; after deductible
Women's Health	Covered 100%; deductible waived	20%; 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%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	20%; after deductible
Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.		
Routine Eye Exams	Covered 100%; deductible waived	20%; after deductible
1 routine exam per 12 months.		
Newborn Hearing Testing and Monitoring	Covered 100%; deductible waived	20%; deductible waived
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP)	Covered 100%; after deductible	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Telemedicine Consultation with Non-Specialist	Covered 100%; after deductible	20%; after deductible
Specialist Office Visits	Covered 100%; after deductible	20%; after deductible
Telemedicine Consultation with Specialist	Covered 100%; after deductible	20%; after deductible
Hearing Exams	Covered 100%; deductible waived	20%; after deductible
1 routine exam per 24 months.		
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	Covered 100%; after deductible **Designated Walk-in Clinics** Covered 100%; after deductible	20%; 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	Your cost sharing is based on the type of service and where it is performed; Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed

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DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	Covered 100%; after deductible	20%; 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%; after deductible	20%; 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%; after deductible	20%; 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	Covered 100%; after deductible	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Covered 100%; after deductible	20%; after deductible
Emergency Room	Covered 100%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%; after deductible	20%; 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%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	20%; 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%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Mental Health Telemedicine Consultations	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; after deductible	20%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	20%; after deductible
Substance Abuse Office Visits	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Substance Abuse Telemedicine Consultations Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Other Substance Abuse Services	Covered 100%; after deductible	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Home Health Care Limited to 60 visits per year Private Duty Nursing not covered Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	20%; after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 60 visits per year	Covered 100%; after deductible	20%; after deductible
Outpatient Short-Term Rehabilitation Limited to 60 visits per year Includes speech, physical, occupational therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Physical Therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Occupational Therapy	Covered 100%; after deductible	20%; after deductible
Habilitative Speech Therapy	Covered 100%; after deductible	20%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Covered 100%; after deductible	20%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Covered 100%; after deductible	20%; after deductible
Autism Physical Therapy	Covered 100%; after deductible	20%; after deductible
Autism Occupational Therapy	Covered 100%; after deductible	20%; after deductible
Autism Speech Therapy	Covered 100%; after deductible	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Prosthetics	Covered 100%; after deductible	20%; after deductible
Orthotics	Covered 100%; after deductible	20%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Covered 100%; after deductible	20%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Covered 100%; after deductible	20%; after deductible

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Hearing Aids	Covered 100%; after deductible	20%; after deductible
Limited to:1 hearing aid per ear to $1,000 maximum per ear every 24 months for child to age 16.		
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Acupuncture	Covered 100%; after deductible	20%; after deductible
Limited to 10 visits per year		
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
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	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
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)	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
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 only.		
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan - Aetna	
		20% of submitted cost
Generic Drugs		
Retail	$15 copay	20% of submitted cost
Mail Order	$30 copay	20% of submitted cost
Preferred Brand-Name Drugs		
Retail	$25 copay	20% of submitted cost
Mail Order	$50 copay	20% of submitted cost
Non-Preferred Brand-Name Drugs		
Retail	$40 copay	20% of submitted cost
Mail Order	$80 copay	20% of submitted cost
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	Up to a 30 day supply Advanced Control Formulary Aetna Insured List	

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Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Contraceptives covered up to a 12 month supply. Contraceptive copay strategy applies.
A limited list of over-the-counter medications are covered when filled with a prescription.
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
Advanced Control Formulary Aetna Insured Step Therapy
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. Also includes male condoms.

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.

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.
• 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.

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.