Y.A.L.E. SCHOOL INC.
Effective Date: 07-01-2024
QPOS® - New Jersey

**PLAN DESIGN & BENEFITS**
**PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK**

| PLAN FEATURES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Benefit limitations** - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more. | | |
| **Deductible** (per calendar year) | $500 per Individual<br>$1,000 per Family | $5,000 per Individual<br>$15,000 per Family |
| Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible.<br>You must first meet the deductible before the plan begins paying benefits, unless otherwise noted.<br>The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details.<br>Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible. | | |
| **Out-of-pocket limit** (per calendar year) | $1,500 per Individual<br>$3,000 per Family | $15,000 per Individual<br>$45,000 per Family |
| Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit.<br>Some of your cost sharing may not count toward the out-of-pocket limit.<br>Your pharmacy expenses count toward your out-of-pocket limit.<br>In-Network expenses include coinsurance/copays and deductibles.<br>Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply<br>Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount. | | |
| **Lifetime maximum** | Unlimited except where otherwise indicated. | Unlimited except where otherwise indicated. |
| **Payment for Out-of-Network Care**** | Does not apply | Professional: 105% of Medicare<br>Facility: 140% of Medicare |
| **Primary care physician selection** | Required | Does not apply |
| **Precertification Requirement:** Certain out-of-network services require precertification or benefits will be reduced by 50%. Refer to your plan documents for a complete list of services that require precertification. | | |
| **Referral requirement** | You'll need a PCP referral for most in-network services | None |
| **Telehealth consultations** - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts. | | |
| **PREVENTIVE CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Routine adult physical exams/ immunizations**<br>1 exam every 12 months | Covered 100%; no deductible | 50%; after deductible |
| **Routine well child exams**<br>• 7 exams in the first 12 months<br>• 3 exams from age 13 to 24 months<br>• 3 exams from age 25 to 36 months<br>• 1 exam every 12 months thereafter until age 22 | Covered 100%; no deductible | 50%; no deductible |
| **Childhood immunizations** | Covered 100%; no deductible | 50%; no deductible |
| **Routine gynecological care exams**<br>1 exam and pap smear per year, including related fees | Covered 100%; no deductible | 50%; after deductible |
| **Routine mammogram**<br>Recommended: One per year for members age 40 and over | Covered 100%; no deductible | 50%; after deductible |

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| **Women's health** | Covered 100%; no deductible | 50%; 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.<br>Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply. | | |
| **Pre-natal maternity** | Covered 100%; no deductible | 50%; after deductible |
| **Routine digital rectal exams / Prostate specific antigen test** | Covered 100%; no deductible | Covered same as routine well adult exam |
| Recommended: For members age 40 and over | | |
| **Colorectal cancer screening** | Covered 100%; no deductible | 50%; after deductible |
| Recommended: For all members age 45 and over. Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.<br>Frequency schedule applies. | | |
| **Routine eye exams** | Covered 100%; no deductible<br>1 routine exam per 24 months. | 50%; after deductible<br>1 routine exam per 24 months. |
| Direct access to participating providers without a referral. | | |
| **Routine hearing screening** | Covered 100%; no deductible | 50%; after deductible |
| **Newborn hearing testing and monitoring** | Subject to routine physical exam cost sharing. | Your cost sharing amount depends on the type of service and where you receive it. |
| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Primary care physician visits** | $20 office visit copay; no deductible | 50%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Telehealth consultation with non-specialist** | $20 office visit copay; no deductible | 50%; after deductible |
| **Specialist office visits** | $40 office visit copay; no deductible | 50%; after deductible |
| **Telehealth consultation with specialist** | $40 office visit copay; no deductible | 50%; after deductible |
| This is how much you pay for the services of an internist, general physician, family practitioner, or pediatrician if the physician is not your PCP. | | |
| **Walk-in clinics** | $20 copay; no deductible | 50%; after deductible |
| Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. | | |
| Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. | | |
| **Allergy testing** | Your cost sharing amount depends on the type of service and where you receive it. | Your cost sharing amount depends on the type of service and where you receive it. |
| **Allergy injections** | Your cost sharing amount depends on the type of service and where you receive it. Covered 100% when an office visit charge is not applicable. | Your cost sharing amount depends on the type of service and where you receive it. |
| **Hearing exams** | Your cost sharing amount depends on the type of service and where you receive it. | |

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| DIAGNOSTIC PROCEDURES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Diagnostic X-ray** (Other than complex imaging services) | Covered 100%; no deductible | 50%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | | |
| **Diagnostic laboratory** | Covered 100%; no deductible | 50%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | | |
| **Diagnostic complex imaging** | Covered 100%; no deductible | 50%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | | |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Urgent care provider** | $30 office visit copay; no deductible | 50%; after deductible |
| **Non-urgent use of urgent care provider** | $30 office visit copay; no deductible | 50%; after deductible |
| **Emergency room** Copay waived if admitted | $100 copay; no deductible | Same as in-network care |
| **Non-emergency care in an emergency room** | Not Covered | Not Covered |
| **Emergency use of ambulance** | Covered 100%; no deductible | Same as in-network care |
| **Non-emergency use of ambulance** | Not Covered | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient coverage** | 30%; after deductible | 50% per admission; after deductible |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Inpatient maternity coverage** (includes delivery and postpartum care) | $40 for Physician Maternity Services; no deductible; 30% for Facility services; after deductible | 50%; after deductible |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Outpatient hospital** | 30%; after deductible | 50% per visit; after deductible |
| When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | | |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 30%; after deductible | 50% per admission; after deductible |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Mental health office visits** | $40 copay; no deductible | 50% per visit; after deductible |
| **Mental health telehealth consultations** | $40 office visit copay; no deductible | 50%; after deductible |
| **Other mental health services** | Covered 100%; no deductible | 50%; after deductible |
| When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | | |
| **SUBSTANCE ABUSE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 30%; after deductible | 50% per admission; after deductible |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Residential treatment facility** | 30%; after deductible | 50% per admission; after deductible |
| When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Substance abuse office visits** | $40 copay; no deductible | 50% per visit; after deductible |
| **Substance abuse telehealth consultations** | $40 office visit copay; no deductible | 50%; after deductible |

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| **Other substance abuse services** | Covered 100%; no deductible | 50%; after deductible |
| When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | | |
| **THERAPY SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Spinal manipulation therapy** | $25 copay; no deductible<br>Limited to 20 visits per year | 50%; after deductible<br>Limited to 20 visits per year |
| **Outpatient short-term rehabilitation** | $40 copay; no deductible<br><br>Limited to 60 visits per year | 50%; after deductible<br><br>Limited to 60 visits per year |
| Includes speech, physical, occupational therapy | | |
| **Habilitative physical therapy** | $40 copay; no deductible | 50%; after deductible |
| **Habilitative occupational therapy** | $40 copay; no deductible | 50%; after deductible |
| **Habilitative speech therapy** | $40 copay; no deductible | 50%; after deductible |
| **Autism related physical therapy** | $40 copay; no deductible | 50%; after deductible |
| **Autism related occupational therapy** | $40 copay; no deductible | 50%; after deductible |
| **Autism related speech therapy** | $40 copay; no deductible | 50%; after deductible |
| **Autism related behavioral therapy** | Refer to MBH Outpatient Mental Health | Refer to MBH Outpatient Mental Health |
| These benefits are combined with outpatient mental health visits. | | |
| **Autism related applied behavior analysis** | Refer to MBH Outpatient Mental Health Other Services | Refer to MBH Outpatient Mental Health Other Services |
| Your benefits for these services are the same as any other outpatient mental health other services benefit | | |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled nursing facility** | 30%; after deductible<br>Limited to 120 days per year | 50%; after deductible<br>Limited to 120 days per year |
| When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Home health care** | Covered 100%; no deductible | 50%; after deductible |
| Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less. | | |
| **Hospice care - inpatient** | 30%; after deductible | 50% per admission; after deductible |
| When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Hospice care - outpatient** | Covered 100%; no deductible | 50%; after deductible |
| When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | | |
| **Durable medical equipment** | 20%; no deductible | 50%; after deductible (must precertify if over $1,500) |
| **Prosthetics** | $20 copay; no deductible | 50%; after deductible |
| **Orthotics**<br>Orthotic Appliances and Services | $20 copay; no deductible | 50%; after deductible |
| **Diabetic supplies -- (if not covered under the prescription drug benefit)** | Covered same as any other medical expense.<br><br>You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount. | Covered same as any other medical expense.<br><br>You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount. |

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| **Hearing aids** | $20 copay | 50%; after deductible |
| 1 hearing aid per ear to $1,000 maximum per ear every 24 months for child to age 16. | | |
| **Vision eyewear** | Covered 100% up to $70 every24 months; not subject to any plan deductible, if applicable | Covered same as participating provider benefit. |
| **Transplants** | 30%; after deductible<br>In-network coverage is only available at Institutes of Excellence (IOE) contracted facility. | 50%; after deductible<br>Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility. |
| **Bariatric surgery** | 30% per admission; after deductible | 50%; after deductible |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Acupuncture** | $20 copay; no deductible | 50%; after deductible |
| Limited to 10 visits per year | | |
| **FAMILY PLANNING** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Infertility treatment** | Your cost sharing amount depends on the type of service and where you receive it. | Your cost sharing amount depends on the type of service and where you receive it. |
| You have coverage for the diagnosis and treatment of the underlying cause of infertility. | | |
| **Comprehensive infertility services** | Your cost sharing amount depends on the type of service and where you receive it. | Your cost sharing amount depends on the type of service and where you receive it. |
| 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 amount depends on the type of service and where you receive it. | Your cost sharing amount depends on the type of service and where you receive it. |
| 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%; no deductible | Your cost sharing amount depends on the type of service and where you receive it. |
| **Tubal ligation** | Covered 100%; no deductible | Your cost sharing amount depends on the type of service and where you receive it. |

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| PRESCRIPTION DRUG BENEFITS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Pharmacy plan type** | Advanced Control Plan - Aetna | |
| **Prescription Drug Deductible** (per calendar year) | $100 per Individual | Not Applicable |
| | $200 per Family | Not Applicable |
| All covered prescription drug expenses add up toward the prescription drug deductible.<br>You must first meet the prescription drug deductible before the plan begins paying prescription drug benefits, unless otherwise noted.<br>Once family pharmacy deductible is met, all family members will be considered as having met their pharmacy deductible for the remainder of the year. | | |
| **Prescription drug out-of-pocket limit** | Prescription drug expenses apply to your medical out-of-pocket limit. | |
| **Generic drugs** | | |
| **Retail** | $20 copay | Not Covered |
| **Mail order** | $40 copay | Not Applicable |
| **Preferred brand-name drugs** | | |
| **Retail** | $40 copay | Not Covered |
| **Mail order** | $80 copay | Not Applicable |
| **Non-preferred brand-name drugs** | | |
| **Retail** | $70 copay | Not Covered |
| **Mail order** | $140 copay | Not Applicable |
| **Pharmacy day supply and requirements** | | |
| **Retail** | You can get up to a 30-day supply from Aetna National Network<br>For a 31-90 day supply you will be responsible for the Mail Order Drug copay. | |
| **Mail order** | You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy. | |
| **Specialty** | You can get up to a 30-day supply of specialty drugs<br>Advanced Control Formulary Aetna Insured List | |
| **Your prescription drug plan also includes:**<br>• Diabetic supplies<br>• $25 copay maximum per fill per 30 day supply for formulary insulin drugs; no deductible for formulary insulin drugs<br>• A limited list of over-the-counter medications when filled with a prescription | | |
| **Family planning**<br>• Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).<br>• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies. | | |
| **The following are covered 100% in-network:**<br>• Oral chemotherapy drugs<br>• Seasonal vaccinations<br>• Preventive vaccinations<br>• Affordable Care Act (ACA) eligible preventive medications<br>Refer to **Aetna.com** for a complete list of eligible prescription drugs. | | |
| **Precertification requirements -**<br>Some covered prescription drugs need approval from us before we will cover the drug.<br>Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.<br>To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website. | | |

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## GENERAL PROVISIONS

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| **Dependents who are eligible to be on your plan** | Spouse, children from birth to age 26. Student status of children does not matter. |

**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.
• 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.
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.
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.
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.

## Exclusions and Limitations

**Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Each insurer has sole financial responsibility for its own products.**

This material is for information only. 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.
• Durable medical equipment.
• 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.
• 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 or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• 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.

**If you require language assistance, please call the member services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).**

**Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).**

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

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.
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.

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