Aetna

Proposed effective date: 10-01-2010
QPOS® - New Jersey

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY – SELF FUNDED

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Deductible (per calendar year)	None Individual None Family	$100 Individual $200 Family
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. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Out-of-Pocket Maximum (per calendar year)	None Individual None Individual	$400 Individual $1200 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred and non-participating providers/participating providers self referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.		
Lifetime Maximum	Unlimited unless otherwise indicated.	Unlimited unless otherwise indicated.
Primary Care Physician Selection	Required	Not Applicable
Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services	None
PREVENTIVE CARE	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	Covered 100%	Covered 100%; deductible waived, 1 visit per 12 months.
Well Child Exams / Immunizations (Age and frequency schedules apply) Includes coverage for blood level screenings. Includes coverage for blood level screenings.	Covered 100%	Covered 100%; deductible waived, preventive care.
Routine Gynecological Care Exams Includes Pap smear and related lab fees. Direct access to participating providers without a referral One exam per calendar year.	Covered 100%	Covered 100%; deductible waived, 1 visit per calendar year.
Routine Mammograms	Covered 100%	Covered 100%; deductible waived, preventive care.
One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over Direct access to participating providers without a referral.		
Routine Digital Rectal Exams / Prostate Specific Antigen Test	Covered 100%.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY – SELF FUNDED

Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies	Covered 100%.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.		
Routine Eye Exam Age/Frequency Schedule may apply. Direct access to participating providers without a referral.	$25 Copay	Not Covered
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing	Subject to Routine Physical Exam benefit.
Newborn Hearing Testing and Monitoring	Subject to Routine Physical Exam cost sharing	20%; deductible waived
Hearing Aids	$20 Copay	20%; after deductible
Coverage for all persons age 15 or younger. One hearing aid for each impaired ear limited to $1,000 per hearing aid every 24 months.		
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Primary Care Physician Visits	Office Hours: $20 copay After Office Hours/Home: $25 copay	20% after deductible, preventive care 100% up to $150 max.
Specialist Office Visits	$25 copay	20% after deductible, preventive care 100% up to $150 max.
Maternity OB Visits	$25 copay for initial visit only, thereafter covered 100%	20% after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing	20% after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing	20% after deductible
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Diagnostic Laboratory	Covered 100%	100% after deductible
If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost sharing.		
Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	Covered 100%	100% after deductible
Diagnostic X-ray for Complex Imaging Services	Covered 100%	100% after deductible
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Emergency Room	$75 copay	Covered if denied in network.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	Covered if denied in network.
Non-Emergency Use of Ambulance	Not Covered	Not Covered

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY – SELF FUNDED

HOSPITAL CARE	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Inpatient Coverage	Covered 100% per admission	100% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	Covered 100% per admission	100% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	Covered 100% per visit	100% per admission; after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Inpatient Biologically Based Mental Illness	Covered 100% per admission	100% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Biologically Based Mental Illness	Covered 100% per admission	100% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based Mental Illness	$25 copay per visit	20% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based Mental Illness	$25 copay per visit	20% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Inpatient Detoxification- Alcohol Abuse	Covered 100% per admission	100% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Detoxification- Drug Abuse	Covered 100% per admission	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification-Alcohol Abuse	$0 copay	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Detoxification-Drug Abuse	$0 copay	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation - Alcohol Abuse	Covered 100% per admission	100% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Rehabilitation - Drug Abuse	Covered 100% per admission	100% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	Covered 100%	30%
Outpatient Rehabilitation - Alcohol Abuse	$25 Copay	20%; after deductible
Outpatient Rehabilitation - Drug Abuse	$25 Copay	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY – SELF FUNDED

OTHER SERVICES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Skilled Nursing Facility	Covered 100% per admission	100% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100%	100% per admission; after deductible Limited to 60 visits per calendar year
Limited to 3 intermittent visit per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 100% per admission	20% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	20% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy)	$25 copay Limited to 60 visits per calendar year.	100% per visit; after deductible
Subluxation	$20 copay Limited to 20 visits per calendar year	20% per visit; after deductible
Prosthetics	Not Covered	20% per visit; after deductible
Orthotics	Not Covered	20% per visit; after deductible
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	20%
Infusion Therapy Home or Office	Covered 100%	Not Covered
Infusion Therapy Outpatient Facility	Covered 100%	Not Covered
Vision Eyewear	$70 once per 24 month period	Not Covered
Transplants	Coverage is provided at an IOE contracted facility only	Coverage is provided at an Non-IOE contracted facility only
Bariatric Surgery	Covered 100% per admission	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
FAMILY PLANNING	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Comprehensive Infertility Services	Applicable copay applies	20%
Advanced Reproductive Technology (ART)	Covered 100%	20%
ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery, limited to 4 complete egg retrievals per lifetime.		
Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing
Dependents Eligibility	Spouse, children from birth to age 26.	

Hair prosthesis covered up to $500 maximum.

Exclusions and Limitations

Plans are provided by: Aetna Health Inc., and Aetna Health 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. Aetna does 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.
- 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.

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY – SELF FUNDED

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si necesita asistencia lingüística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al 1-888-982-3862 (140 idiomas disponibles. Debe solicitar un intérprete). TDD 1-800-628-3323 (para personas con problemas de audición únicamente).

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

For more information about Aetna plans, refer to **www.aetna.com.**