



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**

<b>PLAN FEATURES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Deductible</b> (per calendar year)	None Individual None Family	\$100 Individual \$200 Family
<p>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.</p>		
<b>Out-of-Pocket Maximum</b> (per calendar year)	None Individual None Individual	\$2,000 Individual \$4,000 Family
<p>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.</p>		
<b>Lifetime Maximum</b>	Unlimited unless otherwise indicated.	Unlimited unless otherwise indicated.
<b>Primary Care Physician Selection</b>	Required	Not Applicable
<p><b>Precertification Requirement</b> 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.</p>		
<b>Referral Requirements</b>	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services	None
<b>PREVENTIVE CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Routine Adult Physical Exams / Immunizations</b> (Age and frequency schedules apply)	Covered 100%	30% deductible waived; 1 visit for 12 months.
<b>Well Child Exams / Immunizations</b> (Age and frequency schedules apply) Includes coverage for blood level screenings. Includes coverage for blood level screenings.	Covered 100%	30% deductible waived; no preventive care covered.
<b>Routine Gynecological Care Exams</b> Includes Pap smear and related lab fees. Direct access to participating providers without a referral One exam per calendar year.	Covered 100%	30% deductible waived; 1 visit per calendar year.
<b>Routine Mammograms</b>	Covered 100%	30% deductible waived; state specific; no preventive care.
<p>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.</p>		
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b>	Covered 100%.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.



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<b>Colorectal Cancer Screening</b> 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.		
<b>Routine Eye Exam</b> Age/Frequency Schedule may apply. Direct access to participating providers without a referral.	\$10 Copay	30% after deductible.
<b>Routine Hearing Screening</b>	Covered 100%	30%; after deductible
<b>Newborn Hearing Testing and Monitoring</b>	Covered 100%	30%; after deductible
<b>Hearing Aids</b> 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.	\$10 Copay	30%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Primary Care Physician Visits</b>	Office Hours: \$10 copay After Office Hours/Home: \$20 copay	30% after deductible
<b>Specialist Office Visits</b>	\$10 copay	30% after deductible
<b>Maternity OB Visits</b>	\$0 copay for initial visit only, thereafter covered 100%	30% after deductible
<b>Allergy Treatment</b>	Same as applicable participating provider office visit member cost sharing	30% after deductible
<b>Allergy Testing</b>	Same as applicable participating provider office visit member cost sharing	30% after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Diagnostic Laboratory</b> 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.	Covered 100%	30% after deductible
<b>Diagnostic X-ray</b> Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	Covered 100%	30% after deductible
<b>Diagnostic X-ray for Complex Imaging Services</b>	Covered 100%	30% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Emergency Room</b>	\$50 copay	Covered if denied in network.
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	Covered 100%	Covered if denied in network.
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered



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<b>HOSPITAL CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Inpatient Coverage</b>	Covered 100% per admission	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Inpatient Maternity Coverage</b>	Covered 100% per admission	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Surgery</b>	Covered 100% per visit	30% per admission; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Inpatient Biologically Based Mental Illness</b>	Covered 100% per admission	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Inpatient Non-Biologically Based Mental Illness</b>	Covered 100% per admission	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Biologically Based Mental Illness</b>	\$10 copay per visit	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Outpatient Non-Biologically Based Mental Illness</b>	\$10 copay per visit	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Inpatient Detoxification- Alcohol Abuse</b>	Covered 100% per admission	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Inpatient Detoxification- Drug Abuse</b>	Covered 100% per admission	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Detoxification-Alcohol Abuse</b>	\$10 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Outpatient Detoxification-Drug Abuse</b>	\$10 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Inpatient Rehabilitation - Alcohol Abuse</b>	Covered 100% per admission	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Inpatient Rehabilitation - Drug Abuse</b>	Covered 100% per admission	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Residential Treatment Facility</b>	Covered 100%	30%
<b>Outpatient Rehabilitation - Alcohol Abuse</b>	\$10 Copay	30%; after deductible
<b>Outpatient Rehabilitation - Drug Abuse</b>	\$10 Copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		



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<b>OTHER SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Skilled Nursing Facility</b>	Covered 100% per admission	30% per visit; after deductible Limited to 240 days per calendar year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Home Health Care</b>	Covered 100%	30% 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.		
<b>Hospice Care - Inpatient</b>	Covered 100% per admission	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Hospice Care - Outpatient</b>	Covered 100%	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Private Duty Nursing</b>	Not Covered	Not Covered
<b>Outpatient Rehabilitation Therapy</b> (Includes speech, physical and occupational therapy)	Covered 100%	30% per visit; after deductible.
<b>Subluxation</b> As medically necessary, must be ref'd by PCP except Open Access	\$10 copay	30% per visit; after deductible
<b>Prosthetics</b>	Not Covered	30% after deductible
<b>Orthotics</b>	Not Covered	30% after deductible
<b>Diabetic Supplies</b>	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	Not Covered
<b>Infusion Therapy Home or Office</b>	Covered 100%	Not Covered
<b>Infusion Therapy Outpatient Facility</b>	Covered 100%	Not Covered
<b>Vision Eyewear</b>	\$100 for 24 months	Not Covered
<b>Transplants</b>	Covered 100% per admission	Coverage is provided at an Non-IOE contracted facility only
<b>Bariatric Surgery</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100% per admission	Not Covered
<b>FAMILY PLANNING</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Infertility Treatment</b> 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.
<b>Comprehensive Infertility Services</b>	Applicable copay applies	30%
<b>Advanced Reproductive Technology (ART)</b> 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.	Covered 100%	30%
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing
<b>Dependents Eligibility</b> <b>Hair prosthesis covered up to \$500 maximum.</b>	Spouse, children from birth to age 26.	



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**Exclusions and Limitations**

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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.



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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](http://www.aetna.com)**.

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