PLAN DESIGN AND BENEFITS – STANDARD HEALTH BENEFITS PLAN – NJ INDEMNITY PLAN A2

PLAN FEATURES	
Deductible (per calendar year)	$250 Individual $750 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate toward the Deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. Deductible credit applies. Deductible carryover does not apply.	
Plan Coinsurance *	80% for Inpatient Hospital Care; 50% for All Other Covered Charges
Applies to all expenses unless otherwise stated.	
Maximum Out-of-Pocket (per calendar year, includes deductible)	$7,750 per Individuall
All covered expenses, except pre-approval penalties and amounts over the allowable, accumulate toward the Maximum Out-of-Pocket.	
Lifetime Maximum	$1,000,000 per member lifetime
Provider Payment	Usual & Customary**
Primary Care Physician Selection	Not Applicable
Pre-Approval Requirements – Pre-approval for certain types of care must be obtained to avoid a reduction in benefits paid for that care. Pre-approval is required for: Extended Care and Rehabilitation (Skilled Nursing Facility); Home Health Care; and Hospice Care. Benefits may be reduced by 50% with respect to charges for treatment, services and supplies if pre-approval is not obtained, provided that benefits would otherwise be payable under this plan.	
Referral Requirement	None
PHYSICIAN SERVICES	
Office Visits to Non-Specialist	Not Covered
Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury.	
Specialist Office Visits	Not Covered
Maternity OB Visits	See Inpatient Hospital benefit.
Allergy Testing (given by a physician)	Not Covered
Allergy Injections (not given by a physician)	Not Covered
PREVENTIVE CARE	
Routine Adult Physical Exams / Immunizations; **Well Child Exams / Immunizations;** **Routine Gynecological Care Exams** (Includes Pap smear and related lab fees); **Routine Mammograms;** **Screening Tests;** **Bone Density Tests;** **Nicotine Dependence Treatment**	Calendar Year Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited to $100 per Covered Person and $300 per Family. See Covered Charges with Special Limitations section of the plan documents.

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DIAGNOSTIC PROCEDURES	
Outpatient Diagnostic Laboratory and X-Ray	Only covered if needed for a planned hospital admission or surgery and if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery. Aetna will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health. X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are not covered.
EMERGENCY MEDICAL CARE	
Urgent Care	Not Covered unless admitted.
Emergency Room	Not Covered unless admitted.
Ambulance	Not Covered
HOSPITAL CARE	
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) Limited to 30 days per calendar year. The 30 inpatient days may be exchanged for other types of care: Extended Care and Rehabilitation (Skilled Nursing Facility), Hospice and Home Health Care.	Facility Charges: 80% after $250 hospital confinement copay per day; $1,250 maximum copay per period of confinement; $2,500 maximum copay per Covered Person per Calendar Year; deductible waived. Physician and All Other Charges: 50%.
Outpatient Surgery	Facility Charges: 80%; Physician and All Other Charges: 50%
MENTAL HEALTH SERVICES	
Inpatient Biologically Based Mental Illness	Not Covered
Outpatient Biologically Based Mental Illness	Not Covered
Inpatient Non-Biologically Based Mental Illness	Not Covered
Outpatient Non-Biologically Based Mental Illness	Not Covered
ALCOHOL/DRUG ABUSE SERVICES	
Inpatient Detoxification	Not Covered
Outpatient Detoxification	Not Covered
Inpatient Rehabilitation	Not Covered
Outpatient Rehabilitation	Not Covered

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OTHER SERVICES AND PLAN DETAILS	
Extended Care and Rehabilitation (Skilled Nursing Facility) Subject to pre-authorization, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, Aetna covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. Aetna covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement, but the confinement must: a) start within 14 days of a Hospital stay; and b) be due to the same or a related condition that necessitated the Hospital stay.	Facility Charges: 80% Physician and All Other Charges: 50%
Home Health Care Subject to pre-authorization, when Home Health Care can take the place of Inpatient Hospital care, Aetna covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.	Facility Charges: 80% Physician and All Other Charges: 50%
Hospice Care – Inpatient Subject to pre-authorization, when Hospice Care can take the place of Inpatient Hospital Care, Aetna covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.	Facility Charges: 80% Physician and All Other Charges: 50%
Hospice Care – Outpatient	Not Covered
Private Duty Nursing	Not Covered, except as provided under Home Health Care
Outpatient Rehabilitation Therapy Includes speech, cognitive, physical and occupational therapy for Inpatient Hospital confinement. Speech and cognitive therapy limited to 30 visits (combined) per calendar year; physical and occupational therapy limited to 30 visits (combined) per calendar year. The limitation does not apply to any therapy services that are received under the Home Health Care provision.	Covered only as part of an Inpatient Hospital confinement.
Chiropractic Care (Therapeutic Manipulation)	Not Covered
Durable Medical Equipment	Not Covered
FAMILY PLANNING	
Infertility Treatment	Not Covered
Voluntary Sterilization (Including tubal ligation and vasectomy.)	Member cost sharing is based on the type of service performed and the place where it is rendered.

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PHARMACY – PRESCRIPTION DRUG BENEFITS	
Prescription Drugs	80%
Prescription drugs are only covered while confined in a Hospital on an Inpatient basis only.	
Prescription Drug Deductible (Must be satisfied before any prescription drug benefits are paid.)	Integrated with Medical Deductible

* The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

** Payment for care is determined based on the lowest of: the provider's usual charge for furnishing it; or the charge Aetna determines to be appropriate, based on the factors such as the amount most often charged by a Provider within a given geographic area for the same or similar service or supply, and the manner in which charges for the service or supply are made, but in any event, no greater than a maximum allowable charge based on the 80th percentile of the Prevailing Health Care Systems (PCHS) fee profile, published and available from Ingenix, Inc.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are *generally not covered*.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and dental x-rays.
- Experimental and investigational procedures.
- Eye surgery, such as, radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- Hearing aids.
- Immunizations for travel or work.
- Services or supplies furnished in connection with any procedures to enhance fertility.
- Non-medically necessary services or supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.
- Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products and except as provided in the Food Products for Inherited Metabolic Diseases provision.

Pre-Existing Condition Limitations:

The following provisions only apply to small employers of at least two but not more than five eligible employees. These provisions also apply to "late enrollees" for any small employer. However, this provision does not apply to late enrollees if 10 or more late enrollees request enrollment during any 30 day enrollment period. The "Pre-Existing Conditions" provision does not apply to a dependent who is an adopted child or who is a child placed for adoption or to a newborn child if the employee enrolls the dependent and agrees to make the required payments within 30 days after the dependent's eligibility date.

A Pre-Existing Condition is an illness or injury which manifests itself in the six months before a member's enrollment date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the enrollment date.

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We do not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the enrollment date. This 180 day period may be reduced by the length of time the member was covered under any creditable coverage if, without application of any waiting period, the creditable coverage was continuous to a date not more than 90 days prior to becoming a member. This limitation does not affect benefits for other unrelated conditions or pregnancy, or birth defects in a covered dependent child. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Aetna waives this limitation for a member's Pre-Existing Condition if the condition was payable under creditable coverage which covered the member right before the member's coverage under the Aetna plan started.

If a new member was covered under creditable coverage prior to enrollment under the Aetna plan and the creditable coverage was continuous to a date not more than 90 days prior to the enrollment date under the Aetna plan, we will provide credit as follows. We give credit for the time the member was covered under the creditable coverage without regard to the specific benefits included in the creditable coverage. We will count a period of creditable coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, we give credit for the time the member was covered under the creditable coverage without regard to the specific benefits included in the creditable coverage. We count the days the member was covered under creditable coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation. The person must sign and complete his or her enrollment form within 30 days of the date the employee's active full-time service begins. Any condition arising between the date his or her coverage under the creditable coverage ends and the enrollment date is a Pre-Existing condition. We do not cover any charges actually incurred before the person's coverage starts. If the small employer has included an eligibility waiting period, an employee must still meet it, before becoming covered.

In order to reduce or possibly eliminate the exclusion period based on creditable coverage, please provide Aetna with a copy of any Certificates of Creditable Coverage. Please contact Aetna Member Services at 1-888-80-AETNA if assistance is needed in obtaining a Certificate of Creditable Coverage from prior carriers or with any questions on the information noted above.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Consult the plan documents (i.e., Schedule of Insurance, Small Group Health Benefits Certificate and/or Small Group Health Benefits Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan.

Some benefits are subject to limitations or visit maximums. Certain services require pre-approval, or prior approval of coverage. Failure to pre-approve for these services may lead to substantially reduced benefits. Benefits requiring pre-approval include: Extended Care and Rehabilitation (Skilled Nursing Facility); Home Health Care; and Hospice Care. Member is responsible for obtaining pre-approval for certain services. Pre-approval requirements may vary.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Plans are provided by Aetna Life Insurance Company. While this material is believed to be accurate as of the print date, it is subject to change.