PLAN DESIGN AND BENEFITS - NJ COST-SHARING HMO 1
(Also Marketed As: NJ SGB HMO $20/40% Plan)

PLAN FEATURES	NETWORK PROVIDERS
Deductible (per calendar year)	$2,000 Individual $4,000 Family
Deductible applies to Inpatient Hospital Care (including maternity); Outpatient Surgery; Inpatient Serious Mental Illness or Biologically Based Mental Illness; Inpatient Other than Serious Mental Illness or Non-Biologically Based Mental Illness; Inpatient Detoxification; Inpatient Rehabilitation; Skilled Nursing Facility; Inpatient Hospice and Transplants. Deductible credit applies. Deductible Carryover does not apply.	
Plan Coinsurance *	60%
Maximum Out-of-Pocket (per calendar year)	$5,000 Individual $10,000 Family
Deductible and all covered expenses apply toward the Maximum Out-of-Pocket. Once the Family Maximum Out-of-Pocket is met, all family members will be considered as having met their Maximum Out-of-Pocket for the remainder of the calendar year.	
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Required
Referral Requirement	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services.

PREVENTIVE CARE	NETWORK PROVIDERS
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply.)	$20 Copay
Well Child Exams / Immunizations (Age and frequency schedules apply.)	$20 Copay
Routine Gynecological Care Exams (Limited to one routine exam and pap smear every 365 days.)	$40 Copay
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary.)	$40 Copay
Routine Digital Rectal Exams / Prostate Specific Antigen Test (For males age 40 and over. Age and frequency schedule may apply.)	Member cost sharing is based on the type of service performed and the place where it is rendered.
Colorectal Cancer Screening (For members age 50 and over and to younger members who are considered to be high risk for colorectal cancer as medically necessary. Frequency schedule applies.)	Member cost sharing is based on the type of service performed and the place where it is rendered.
Routine Eye Exams at Specialist (Age and frequency schedules apply.)	$40 Copay
Vision Corrective Lenses/Contacts Allowance	$100 reimbursement payable once for 24-month period
Routine Hearing Screening (Covered as part of a routine physical exam.)	Subject to Routine Physical Exam cost sharing

PHYSICIAN SERVICES	NETWORK PROVIDERS
Primary Care Physician Visits	$20 Copay (Office Hours) $25 Copay (After Hours)
Specialist Office Visits	$40 Copay
Maternity OB Visits	$40 Copay for initial visit only
Allergy Treatment and Testing	Same as applicable network provider office visit member cost sharing

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DIAGNOSTIC PROCEDURES	NETWORK PROVIDERS
Diagnostic Laboratory (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 member cost sharing.)	$40 Copay
Diagnostic X-ray (except for Complex Imaging Services) – Outpatient Hospital or Other Outpatient Facility	$40 Copay
Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans)	$40 Copay
EMERGENCY MEDICAL CARE	**NETWORK PROVIDERS**
Emergency Room (Waived if admitted)	$100 Copay
Urgent Care	$100 Copay
Ambulance	$0 Copay
HOSPITAL CARE	**NETWORK PROVIDERS**
Inpatient Coverage (Including maternity)	60% after deductible
Outpatient Surgery	60% after deductible
MENTAL HEALTH SERVICES	**NETWORK PROVIDERS**
Inpatient Biologically Based Mental Illness	60% after deductible
Outpatient Biologically Based Mental Illness	$40 Copay
Inpatient Non-Biologically Based Mental Illness (Limited to 30 days per calendar year.)	60% after deductible
Outpatient Non-Biologically Based Mental Illness (Limited to 20 visits per calendar year.)	$40 Copay
ALCOHOL/DRUG ABUSE SERVICES	**NETWORK PROVIDERS**
Inpatient Detoxification (Alcohol Abuse is treated the same as any other illness.)	60% after deductible
Outpatient Detoxification (Alcohol Abuse is treated the same as any other illness.)	$40 Copay
Inpatient Rehabilitation (Limited to 30 days per calendar year; 90 days per lifetime. Alcohol Abuse is treated the same as any other illness.)	60% after deductible
Outpatient Rehabilitation (Limited to 20 visits per calendar year. Alcohol Abuse is treated the same as any other illness.)	$40 Copay
OTHER SERVICES	**NETWORK PROVIDERS**
Skilled Nursing Facility (Limited to 120 days per calendar year. Must be in lieu of hospitalization for medically necessary covered benefits.)	60% after deductible
Home Health Care (Limited to 60 visits per calendar year.)	$40 Copay per visit
Hospice Care – Inpatient	60% after deductible
Hospice Care – Outpatient	$0 Copay per visit
Private Duty Nursing	Not Covered, except as provided under Home Health Care
Outpatient Rehabilitation Therapy (Includes speech, cognitive, physical and occupational therapy. Limited to treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment, except for biologically based mental illness which is limited to 30 visits per calendar year.)	$40 Copay per visit
Chiropractic Care (Subluxation) (Limited to 30 visits per calendar year.)	$40 Copay per visit
Durable Medical Equipment (Limited to $2,500 per member per calendar year.)	50%
Transplants	Member cost sharing is based on the type of service performed and the place where it is rendered.

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FAMILY PLANNING	NETWORK PROVIDERS
Infertility Treatment (Coverage for the diagnosis and surgical treatment of the underlying medical cause; artificial insemination and standard dosages, lengths of treatment and cycles of therapy of prescription drugs to enhance fertility. For services and supplies specifically excluded, refer to plan documents and the Exclusions and Limitations below.)	Subject to applicable service type member cost sharing.
Voluntary Sterilization (Including tubal ligation and vasectomy.)	Subject to applicable service type member cost sharing.
ADDITIONAL EMPLOYER PLAN OPTIONS: **The following optional prescription drug benefits are available only if elected by your employer.**	
PHARMACY – PRESCRIPTION DRUG BENEFITS **RX (HMO-*NJ-SGB) $15/25**	**NETWORK PHARMACIES**
Prescription Drugs Up to 30 day supply	$15 Copay for generic drugs and $25 Copay for brand-name drugs
Retail or Mail Order 31 - 90 day supply	$30 Copay for generic drugs and $50 Copay for brand-name drugs
Open Formulary – Covers drugs on the Formulary Exclusion List.	
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only.	
Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.	
Performance Option: Employer may choose to include or exclude drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.	
Pre-certification included.	
Prescription Drug Deductible (per calendar year)	Not Applicable
PHARMACY – PRESCRIPTION DRUG BENEFITS **RX (HMO-*NJ-SG 4/04 2X CPY) $15/25/40**	**NETWORK PHARMACIES**
Prescription Drugs Up to 30 day supply	$15 Copay for generic formulary drugs, $25 Copay for formulary brand-name drugs, and $40 Copay for non-formulary generic and brand-name drugs
Retail or Mail Order 31 - 90 day supply	$30 Copay for generic formulary drugs, $50 Copay for formulary brand-name drugs, and $80 Copay for non-formulary generic and brand-name drugs
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only.	
Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.	
Performance Option: Employer may choose to include or exclude drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.	
Pre-certification included.	
Prescription Drug Deductible (per calendar year)	Not Applicable

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PHARMACY – PRESCRIPTION DRUG BENEFITS RX (HMO-*NJ-SG 4/04 2X CPY) $15/35/60	NETWORK PHARMACIES
Prescription Drugs Up to 30 day supply	$15 Copay for generic formulary drugs, $35 Copay for formulary brand-name drugs, and $60 Copay for non-formulary generic and brand-name drugs
Retail or Mail Order 31 - 90 day supply	$30 Copay for generic formulary drugs, $70 Copay for formulary brand-name drugs, and $120 Copay for non-formulary generic and brand-name drugs
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only.	
Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.	
Performance Option: Employer may choose to include or exclude drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.	
Pre-certification included.	
Prescription Drug Deductible (per calendar year)	Not Applicable

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

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, except as otherwise stated in the contract.
- 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).
- 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 which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT), donor sperm, surrogate motherhood; and b) prescription drugs not eligible under the prescription drugs section of the contract.
- Non-medically necessary services or supplies.
- Orthotics.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.

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.

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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.

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 1-800-70-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 Benefits, Evidence of Coverage and/or Contract) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. Network physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

The pharmacy plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under the prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. The pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as pre-certification, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. In addition, in circumstances where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc.,that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

"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 Health Inc. While this material is believed to be accurate as of the print date, it is subject to change.