

PLAN DESIGN AND BENEFITS - NJ POS NO-REFERRAL 5
(Also Marketed As: NJ SGB \$25/\$500/\$2000 DED AETNA CHOICE POS PLAN)

PLAN FEATURES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible (per calendar year)	Not Applicable	\$2,000 Individual \$4,000 Family
Deductible applies to all covered expenses unless otherwise indicated. 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 *	Not Applicable	80%
Maximum Out-of-Pocket (per calendar year)	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 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. All covered medical expenses accumulate separately toward the Network and Non-Network Maximum Out-of-Pocket.		
Lifetime Maximum	Unlimited	\$5,000,000
Payment for Services from a Non-Network Provider	Not Applicable	Usual and Customary **
Primary Care Physician Selection	Recommended ***	Not Applicable
Pre-Approval Requirements – Certain services require pre-approval or benefits will be reduced. Refer to your plan documents for a complete list of services that require pre-approval.		
Referral Requirement	Not Applicable ***	Not Applicable
PREVENTIVE CARE	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply.)	\$25 Copay	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. \$500 combined maximum per calendar year for all preventive care. See Covered Charges with Special Limitations section of the plan documents.
Well Child Exams / Immunizations (Age and frequency schedules apply.)	\$25 Copay	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. \$500 combined maximum per calendar year for all preventive care, except \$750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.
Routine Gynecological Care Exams (Limited to one routine exam and pap smear every 365 days. Network and Non-Network combined.)	\$50 Copay	Refer to Adult Physical Exam/Immunizations, Preventive Care Benefit.

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PREVENTIVE CARE (CONTINUED)	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
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. Network and Non-Network combined.)	\$50 Copay	Refer to Adult Physical Exam/Immunizations, Preventive Care Benefit.
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.	Refer to Adult Physical Exam/Immunizations, Preventive Care Benefit.
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.	Refer to Adult Physical Exam/Immunizations, Preventive Care Benefit.
Routine Eye Exams at Specialist (Age and frequency schedules apply.)	\$50 Copay	Not Covered, except vision screening for covered dependent children through age 17, 80%.
Vision Corrective Lenses/Contacts Allowance	\$100 reimbursement payable once for 24-month period	Not Covered
Routine Hearing Screening (Covered as part of a routine physical exam.)	Subject to Routine Physical Exam cost sharing	Not Covered, except screenings as provided by Preventive Care Benefit.
PHYSICIAN SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Primary Care Physician Visits ***	\$25 Copay (Office Hours) *** \$30 Copay (After Hours) ***	80%
Specialist Office Visits ***	\$50 Copay ***	80%
Maternity OB Visits	\$50 Copay for initial visit only	80%
Allergy Testing and Treatment	Same as applicable network provider office visit member cost sharing	80%
DIAGNOSTIC PROCEDURES	NETWORK PROVIDERS	NON-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.)	\$50 Copay	80%
Diagnostic X-ray (except for Complex Imaging Services) – Outpatient Hospital or Other Outpatient Facility	\$50 Copay	80%
Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans)	\$50 Copay	80%
EMERGENCY MEDICAL CARE	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Urgent Care	\$100 Copay	Paid as Network
Emergency Room (Waived if admitted)	\$100 Copay	Paid as Network
Ambulance	\$0 Copay	Paid as Network
HOSPITAL CARE	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Inpatient Coverage (Including maternity)	\$500 Copay per admission	80%
Outpatient Surgery	\$0 Copay	80%

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MENTAL HEALTH SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Inpatient Biologically Based Mental Illness	\$500 Copay per admission	80%
Outpatient Biologically Based Mental Illness	\$50 Copay	80%
Inpatient Non-Biologically Based Mental Illness (Limited to 30 days per calendar year. Network and Non-Network combined.)	\$500 Copay per admission	80%
Outpatient Non-Biologically Based Mental Illness (Limited to 20 visits per calendar year. Network and Non-Network combined. Non-Network: \$30 maximum benefit payable per visit.)	\$50 Copay	80%
ALCOHOL/DRUG ABUSE SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Inpatient Detoxification (Drug Abuse: Limited to 30 days per calendar year. Network and Non-Network combined. Alcohol Abuse is treated the same as any other illness.)	\$500 Copay per admission	80%
Outpatient Detoxification (Alcohol Abuse is treated the same as any other illness.)	\$50 Copay	80%
Inpatient Rehabilitation (Drug Abuse: Limited to 30 days per calendar year; 90 days per lifetime. Network and Non-Network combined. Alcohol Abuse is treated the same as any other illness.)	\$500 Copay per admission	80%
Outpatient Rehabilitation (Drug Abuse: Limited to 20 visits per calendar year. Network and Non-Network combined. Alcohol Abuse is treated the same as any other illness.)	\$50 Copay	80%
OTHER SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Skilled Nursing Facility (Limited to 120 days per calendar year. Must be in lieu of hospitalization for medically necessary covered benefits. Network and Non-Network combined.)	\$0 Copay per admission	80%
Home Health Care (Limited to 60 visits per calendar year. Network and Non-Network combined.)	\$0 Copay per visit	80%
Hospice Care – Inpatient	\$0 Copay per admission	80%
Hospice Care – Outpatient	\$0 Copay per visit	80%
Private Duty Nursing	Not Covered, except as provided under Home Health Care	Not Covered, except as provided under Home Health Care
Outpatient Rehabilitation Therapy (Includes speech, cognitive, physical and occupational therapy. Speech and cognitive therapy limited to 30 visits (combined) per calendar year; physical and occupational therapy limited to 30 visits (combined) per calendar year. Network and Non-Network combined.)	\$0 Copay per visit	80%
Chiropractic Care (Subluxation) (Limited to 30 visits per calendar year. Network and Non-Network combined.)	\$0 Copay per visit	80%

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OTHER SERVICES (CONTINUED)		NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Durable Medical Equipment (Limited to \$2,500 per member per calendar year. Network and Non-Network combined.)		50%	50%
Transplants (Coverage provided at an IOE contracted facility, subject to Network cost-sharing. Coverage provided at a non-IOE facility, subject to Non-Network cost-sharing.)		Member cost sharing is based on the type of service performed and the place where it is rendered.	Member cost sharing is based on the type of service performed and the place where it is rendered.
FAMILY PLANNING		NETWORK PROVIDERS	NON-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.)		Member cost sharing is based on the type of service performed and the place where it is rendered.	80%
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.	80%
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	NON-NETWORK PHARMACIES
Prescription Drugs Up to 30 day supply		\$15 Copay for generic drugs and \$25 Copay for brand-name drugs	80%
Retail or Mail Order 31 - 90 day supply		\$30 Copay for generic drugs and \$50 Copay for brand-name drugs	80%
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	Integrated with Medical
PHARMACY – PRESCRIPTION DRUG BENEFITS – Rx (HMO - *NJ-SG 4/04 2X CPY) \$15/25/40		NETWORK PHARMACIES	NON-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	80%
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	80%
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	Integrated with Medical

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PHARMACY – PRESCRIPTION DRUG BENEFITS – Rx (HMO - *NJ-SG 4/04 2X CPY) \$15/35/60	NETWORK PHARMACIES	NON-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	80%
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	80%
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	Integrated with Medical

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

** Non-Network Provider payments are 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.

*** A member may at anytime seek health care from Network Providers without first contacting his or her Primary Care Physician. When a member chooses not to use his or her Primary Care Physician, the member is entitled to receive benefits for covered services and supplies. However, a member will be subject to the Specialist copayment listed when a member accesses a PCP other than their selected PCP. A member who does not select a PCP will be subject to Specialist copayment when a Member obtains covered benefits from any Network PCP or Network Specialist.

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.

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- 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.

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

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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.