HMO Medical Plan Options

New Jersey

FOR BUSINESSES WITH
2 TO 50 ELIGIBLE EMPLOYEES

14.02.927.1-NJ (7/07)

HIGHLIGHTED NEW JERSEY AETNA SMALL GROUP MEDICAL PLANS

HMO PLAN OPTIONS

Additional plans are available. Please contact your broker or Aetna.	NJ HMO NO-REFERRAL 1[1,2,*]	NJ HMO NO-REFERRAL 2[1,2,*]	NJ HMO NO-REFERRAL 3[1,2,*]	NJ HMO NO-REFERRAL 4[1,2,*]
MEMBER BENEFITS	Network No Referral Needed	Network No Referral Needed	Network No Referral Needed	Network No Referral Needed
Plan Coinsurance	N/A	N/A	N/A	N/A
Calendar Year Deductible	N/A	N/A	N/A	N/A
Calendar Year Maximum Out-of-Pocket[3] (All amounts paid as copayment and coinsurance for covered services and supplies will apply toward the Maximum Out-of-Pocket)	$2,500 per member $5,000 family	$1,500 per member $3,000 family	$1,500 per member $3,000 family	$1,500 per member $3,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Primary Physician Office Visit	$30 copay	$20 copay	$15 copay	$10 copay
Specialist Office Visit	$50 copay	$40 copay	$30 copay	$20 copay
Outpatient Services – Lab	$50 copay	$40 copay	$30 copay	$20 copay
Outpatient Services – X-Ray	$50 copay	$40 copay	$30 copay	$20 copay
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	$50 copay	$40 copay	$30 copay	$20 copay
Chiropractic Services (30 visits per calendar year)	$50 copay	$40 copay	$30 copay	$20 copay
Outpatient Physical, Occupational, Speech Therapy (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)	$50 copay	$40 copay	$30 copay	$20 copay
Durable Medical Equipment ($2,500 Calendar Year Maximum)	50%	50%	50%	50%
Inpatient Hospital	$500 copay per day, 5 day copay maximum per admission	$250 copay per day, 5 day copay maximum per admission	$125 copay per day, 5 day copay maximum per admission	$0 copay per admission
Outpatient Surgery	$500 copay	$250 copay	$125 copay	$0 copay
Emergency Room (Copay waived if admitted)	$100 copay	$100 copay	$100 copay	$100 copay
Mental Health – Inpatient (Biologically Based: Treated the same as any other illness; Non-Biologically Based: Max. of 30 days per calendar year.)	$500 copay per day, 5 day copay maximum per admission	$250 copay per day, 5 day copay maximum per admission	$125 copay per day, 5 day copay maximum per admission	$0 copay per admission
Substance Abuse – Inpatient (Drug Abuse Detox.: Unlimited days per calendar year; Drug Abuse Rehab.: Max. of 30 days per calendar year; 90 days per lifetime. Alcohol Abuse is treated the same as any other illness.)	$500 copay per day, 5 day copay maximum per admission	$250 copay per day, 5 day copay maximum per admission	$125 copay per day, 5 day copay maximum per admission	$0 copay per admission
Routine Eye Exam	$50 copay	$40 copay	$30 copay	$20 copay
Glasses and Contact Lens Reimbursement	$100/24 month period	$100/24 month period	$100/24 month period	$100/24 month period
Vision One® Discount Program	Included	Included	Included	Included
Prescription Drugs: 30-day supply	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%
Retail or Mail Order: 90-day supply	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
***Optional Features:**	**– Referral Plan Option: NJ HMO 1** **– Inpatient Hospital Copay Waiver[4]**	**– Referral Plan Option: NJ HMO 2** **– Inpatient Hospital Copay Waiver[4]**	**– Referral Plan Option: NJ HMO 3**	**– Referral Plan Option: NJ HMO 4**

1 This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

2 "No Referral" Provision: 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.

3 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. No one family member may contribute more than the individual maximum out-of-pocket amount to the family maximum out-of-pocket.

4 Inpatient Hospital Copay Waiver - When selected, the following services will be subject to $0 copay: Inpatient Hospital (including maternity), Outpatient Surgery, Skilled Nursing Facility, Inpatient Hospice, Inpatient Substance Abuse Services, Inpatient Mental Health, Transplants.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services such as non-emergency hospital care.

NOTE: For a summary list of Limitations and Exclusions, refer to page 5. Please refer to Aetna's Producer World website at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

HIGHLIGHTED NEW JERSEY AETNA SMALL GROUP MEDICAL PLANS

HMO PLAN OPTIONS

Additional plans are available. Please contact your broker or Aetna.	NJ HMO NO-REFERRAL 5[1,2,*]	NJ HMO NO-REFERRAL $20[1,2,*]	NJ HMO NO-REFERRAL $20 W/INPATIENT HOSPITAL COPAY WAIVER[1,2,*]	NJ HMO NO-REFERRAL $30[1,2,*]	NJ HMO NO-REFERRAL $30 W/INPATIENT HOSPITAL COPAY WAIVER[1,2,*]
MEMBER BENEFITS	In-Network No Referral Needed	In-Network No Referral Needed	In-Network No Referral Needed	In-Network No Referral Needed	In-Network No Referral Needed
Plan Coinsurance	N/A	N/A	N/A	N/A	N/A
Calendar Year Deductible	N/A	N/A	N/A	N/A	N/A
Calendar Year Maximum Out-of-Pocket[3] (All amounts paid as copayment and coinsurance for covered services and supplies will apply toward the Maximum Out-of-Pocket.)	$5,000 per member $10,000 family	$5,000 per member $10,000 family	$5,000 per member $10,000 family	$5,000 per member $10,000 family	$5,000 per member $10,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Physician Office Visit	$30 copay	$20 copay	$20 copay	$30 copay	$30 copay
Specialist Office Visit	$50 copay	$20 copay	$20 copay	$30 copay	$30 copay
Outpatient Services – Lab	$50 copay	$20 copay	$20 copay	$30 copay	$30 copay
Outpatient Services – X-Ray	$50 copay	$20 copay	$20 copay	$30 copay	$30 copay
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	$50 copay	$20 copay	$20 copay	$30 copay	$30 copay
Chiropractic Services (30 visits per calendar year)	$50 copay	$20 copay	$20 copay	$30 copay	$30 copay
Outpatient Physical, Occupational, Speech Therapy (Speech and cognitive therapy (combined) limited to 30 visits per calendar year; physical and occupational therapy (combined) limited to 30 visits per calendar year. In-network and out-of-network combined.)	$50 copay	$20 copay	$20 copay	$30 copay	$30 copay
Durable Medical Equipment	50% $2,500 Calendar Year Maximum	$0 copay Unlimited Calendar Year Maximum	$0 copay Unlimited Calendar Year Maximum	$0 copay Unlimited Calendar Year Maximum	$0 copay Unlimited Calendar Year Maximum
Inpatient Hospital	$750 copay per day, 5 day copay maximum per admission	$200 copay per day, 5 day copay maximum per admission, $2,000 calendar year maximum	$0 copay per admission	$300 copay per day, 5 day copay maximum per admission, $3,000 calendar year maximum	$0 copay per admission
Outpatient Surgery	$750 copay	$20 copay	$0 copay	$30 copay	$0 copay
Emergency Room (Copay waived if admitted.)	$100 copay	$50 copay	$50 copay	$50 copay	$50 copay
Mental Health – Inpatient (Biologically Based: Treated the same way as any other illness. Non-Biologically Based: Max. of 30 days per calendar year.)	$750 copay per day, 5 day copay maximum per admission	$200 copay per day, 5 day copay maximum per admission, $2,000 calendar year maximum	$0 copay per admission	$300 copay per day, 5 day copay maximum per admission, $3,000 calendar year maximum	$0 copay per admission
Substance Abuse – Inpatient	$750 copay per day, 5 day copay maximum per admission Detox.: Unlimited days per calendar year. Rehab.: Max. of 30 days per calendar year; 90 days per lifetime. Alcohol abuse is treated the same as any other illness.	$200 copay per day, 5 day copay maximum per admission, $2,000 calendar year maximum Max. of 30 days per calendar year. Alcohol abuse is treated the same as any other illness.	$0 copay per admission Max. of 30 days per calendar year. Alcohol abuse is treated the same as any other illness.	$300 copay per day, 5 day copay maximum per admission, $3,000 calendar year maximum Max. of 30 days per calendar year. Alcohol abuse is treated the same as any other illness.	$0 copay per admission Max. of 30 days per calendar year. Alcohol abuse is treated the same as any other illness.
Routine Eye Exam	$50 copay	Not Covered	$20 copay	Not Covered	$30 copay
Glasses and Contact Lens Reimbursement	$100/24 month period	Not Covered	$100/24 month period	Not Covered	$100/24 month period
Vision One™ Discount Program	Included	Included	Included	Included	Included
Prescription Drugs: 30-day supply	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%
Retail or Mail Order: 90-day supply	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%
Contraceptives and Diabetic Supplies	Included	Included	Included	Included	Included
***Optional Features:**	**– Referral Plan Option: NJ HMO 5**	**– Referral Plan Option: NJ HMO $20 Plan (Standard Health Benefits Plan Option) Available With and Without Rx Riders**	**– Referral Plan Option: NJ HMO $20 Plan w/Inpatient Hospital Copay Waiver**	**– Referral Plan Option: NJ HMO $30 Plan (Standard Health Benefits Plan Option) Available With and Without Rx Riders**	**– Referral Plan Option: NJ HMO $30 Plan w/Inpatient Hospital Copay Waiver**

1 This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

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3 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. No one family member may contribute more than the individual maximum out-of-pocket amount to the family maximum out-of-pocket.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services such as non-emergency hospital care.

NOTE: For a summary list of Limitations and Exclusions, refer to page 5. Please refer to Aetna's Producer World website at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

COST-SHARING HMO PLAN OPTIONS

Additional plans are available. Please contact your broker or Aetna.	NJ COST-SHARING HMO NO-REFERRAL 1[1,2,*]	NJ COST-SHARING HMO NO-REFERRAL 2[1,2,*]	NJ COST-SHARING HMO NO-REFERRAL 3[1,2,*]	NJ COST-SHARING HMO NO-REFERRAL 9[1,2,*]
MEMBER BENEFITS	Network No Referral Needed	Network No Referral Needed	Network No Referral Needed	Network No Referral Needed
Plan Coinsurance	60% after deductible	70% after deductible	80% after deductible	80% after deductible
Calendar Year Deductible[3]	$2,000 per member $4,000 family	$1,000 per member $2,000 family	$500 per member $1,000 family	$1,000 per member $2,000 family
Calendar Year Maximum Out-of-Pocket[4] (All amounts paid as deductible, copayment and coinsurance for covered services and supplies will apply toward the Maximum Out-of-Pocket)	$5,000 per member $10,000 family	$4,000 per member $8,000 family	$2,500 per member $5,000 family	$1,500 per member $3,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Primary Physician Office Visit	$20 copay	$15 copay	$10 copay	$20 copay
Specialist Office Visit	$40 copay	$30 copay	$20 copay	$30 copay
Outpatient Services – Lab	$40 copay	$30 copay	$20 copay	$30 copay
Outpatient Services – X-Ray	$40 copay	$30 copay	$20 copay	$30 copay
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	$40 copay	$30 copay	$20 copay	$30 copay
Chiropractic Services (30 visits per calendar year)	$40 copay	$30 copay	$20 copay	$30 copay
Outpatient Physical, Occupational, Speech Therapy (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	$30 copay	$20 copay	$30 copay
Durable Medical Equipment	50% $2,500 Calendar Year Maximum	50% $2,500 Calendar Year Maximum	50% $2,500 Calendar Year Maximum	80% Unlimited Calendar Year Maximum
Inpatient Hospital	60% after deductible	70% after deductible	80% after deductible	80% after deductible
Outpatient Surgery	60% after deductible	70% after deductible	80% after deductible	80% after deductible
Emergency Room (Copay waived if admitted)	$100 copay	$100 copay	$100 copay	$50 copay
Mental Health – Inpatient (Biologically Based: Treated the same way as any other illness. Non-Biologically Based: Max. of 30 days per calendar year.)	60% after deductible	70% after deductible	80% after deductible	80% after deductible
Substance Abuse – Inpatient (Detox.: Unlimited days per calendar year. Rehab.: Max. of 30 days per calendar year; 90 days per lifetime. Alcohol abuse is treated the same as any other illness.)	60% after deductible	70% after deductible	80% after deductible	80% after deductible
Routine Eye Exam	$40 copay	$30 copay	$20 copay	$30 copay
Glasses and Contact Lens Reimbursement	$100/24 month period	$100/24 month period	$100/24 month period	$100/24 month period
Vision One® Discount Program	Included	Included	Included	Included
Prescription Drugs: 30-day supply	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%
Retail or Mail Order: 90-day supply	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
***Optional Features:**	**– Referral Plan Option: NJ Cost-Sharing HMO 1**	**– Referral Plan Option: NJ Cost-Sharing HMO 2**	**– Referral Plan Option: NJ Cost-Sharing HMO 3**	**– Referral Plan Option: NJ Cost-Sharing HMO 9**

1 This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

2 "No Referral" Provision: 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.

3 Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

4 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. No one family member may contribute more than the individual maximum out-of-pocket amount to the family maximum out-of-pocket.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services such as non-emergency hospital care.

NOTE: For a summary list of Limitations and Exclusions, refer to page 5. Please refer to Aetna's Producer World website at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

HIGHLIGHTED NEW JERSEY AETNA SMALL GROUP MEDICAL PLANS

COST-SHARING HMO PLAN OPTIONS

Additional plans are available. Please contact your broker or Aetna.	NJ COST-SHARING HMO NO-REFERRAL 4[1,2,*]	NJ COST-SHARING HMO NO-REFERRAL 8[1,2,*]
MEMBER BENEFITS	Network No Referral Needed	Network No Referral Needed
Plan Coinsurance	50% after deductible	70% after deductible
Calendar Year Deductible[3]	$2,500 per member $5,000 family	$1,500 per member $3,000 family
Calendar Year Maximum Out-of-Pocket[4] (All amounts paid as deductible, copayment and coinsurance for covered services and supplies will apply toward the Maximum Out-of-Pocket)	$5,000 per member $10,000 family	$3,000 per member $6,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited
Primary Physician Office Visit	$30 copay	$25 copay
Specialist Office Visit	$50 copay	$40 copay
Outpatient Services – Lab	$50 copay	$40 copay
Outpatient Services – X-Ray	$50 copay	$40 copay
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	$50 copay	$40 copay
Chiropractic Services (30 visits per calendar year)	$50 copay	$40 copay
Outpatient Physical, Occupational, Speech Therapy (Speech and cognitive therapy (combined) limited to 30 visits per calendar year; physical and occupational therapy (combined) limited to 30 visits per calendar year.)	$50 copay	$40 copay
Durable Medical Equipment ($2,500 Calendar Year Maximum)	50%	50%
Inpatient Hospital	50% after deductible	70% after deductible
Outpatient Surgery	50% after deductible	70% after deductible
Emergency Room (Copay waived if admitted)	$100 copay	$100 copay
Mental Health – Inpatient (Biologically Based: Treated the same way as any other illness. Non-Biologically Based: Max. of 30 days per calendar year.)	50% after deductible	70% after deductible
Substance Abuse – Inpatient (Detox.: Unlimited days per calendar year. Rehab.: Max. of 30 days per calendar year; 90 days per lifetime. Alcohol abuse is treated the same as any other illness.)	50% after deductible	70% after deductible
Routine Eye Exam	$50 copay	$40 copay
Glasses and Contact Lens Reimbursement	$100/24 month period	$100/24 month period
Vision One® Discount Program	Included	Included
Prescription Drugs: 30-day supply	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%	Option 1: $20/$40/$70 Option 2: $15/$35/$60 Option 3: $15/$25/$40 Option 4: $15/$25 Option 5: 50%
Retail or Mail Order: 90-day supply	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%	Option 1: $40/$80/$140 Option 2: $30/$70/$120 Option 3: $30/$50/$80 Option 4: $30/$50 Option 5: 50%
Contraceptives and Diabetic Supplies	Included	Included
***Optional Features:**	**– Referral Plan Option: NJ Cost-Sharing HMO 4**	**– Referral Plan Option: NJ Cost-Sharing HMO 8**

1 This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

2 "No Referral" Provision: 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.

3 Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

4 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. No one family member may contribute more than the individual maximum out-of-pocket amount to the family maximum out-of-pocket.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services such as non-emergency hospital care.

NOTE: For a summary list of Limitations and Exclusions, refer to page 5. Please refer to Aetna's Producer World website at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Medical Exclusions and Limitations

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 Intrafallopian 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.
- Nonmedically necessary services or supplies.
- Orthotics.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.

Pre-Existing Conditions Exclusion Provision

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.

Notes

For more information about Aetna's Small Business Solutions, please contact the Northeast Small Group Sales Support Center at 1-888-277-1053 or the Mid-Atlantic Small Group Sales Support Center at 1-877-28-AETNA.

Health benefits and health insurance plans/policies are offered, underwritten or administered by Aetna Health Inc.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location.

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.

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. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group. In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Aetna's condition management programs are intended to encourage compliance with appropriate care. You should use your own your clinical judgment regarding the appropriate treatment of any individual patient.

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Discount programs provide access to discounted prices and are not insured benefits. Vision One® is a registered trademark of Cole Vision Corporation.

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.

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

Information is subject to change.

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