

Consumer Directed Medical Plan Options



New Jersey

FOR BUSINESSES WITH
2 TO 50 ELIGIBLE EMPLOYEES

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (AETNA).

HIGHLIGHTED NEW JERSEY AETNA SMALL GROUP MEDICAL PLANS

CONSUMER DIRECTED – HMO HSA-COMPATIBLE PLAN OPTIONS

Additional plans are available. Please contact your broker or Aetna.	NJ HMO HSA COMPATIBLE NO-REFERRAL 1 1,2	NJ HMO HSA COMPATIBLE NO-REFERRAL 2 1,2	NJ HMO HSA COMPATIBLE NO-REFERRAL 3 1,2	NJ HMO HSA COMPATIBLE NO-REFERRAL 4 1,2
MEMBER BENEFITS	Network No Referral Needed	Network No Referral Needed	Network No Referral Needed	Network No Referral Required
Plan Coinsurance	N/A	N/A	N/A	N/A
Calendar Year Deductible ³	\$2,500 individual \$5,000 family	\$1,500 individual \$3,000 family	\$2,500 individual \$5,000 family	\$2,000 individual \$4,000 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 individual \$10,000 family	\$3,000 individual \$6,000 family	\$2,500 individual \$5,000 family	\$4,000 individual \$8,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Primary Physician Office Visit	\$30 copay after deductible	\$20 copay after deductible	\$0 copay after deductible	\$25 copay after deductible
Specialist Office Visit	\$50 copay after deductible	\$30 copay after deductible	\$0 copay after deductible	\$40 copay after deductible
Outpatient Services – Lab	\$50 copay after deductible	\$30 copay after deductible	\$0 copay after deductible	\$40 copay after deductible
Outpatient Services – X-Ray	\$50 copay after deductible	\$30 copay after deductible	\$0 copay after deductible	\$40 copay after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 copay after deductible	\$100 copay after deductible	\$0 copay after deductible	\$100 copay after deductible
Chiropractic Services (30 visits per calendar year.)	\$50 copay after deductible	\$30 copay after deductible	\$0 copay after deductible	\$40 copay after deductible
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 after deductible	\$30 copay after deductible	\$0 copay after deductible	\$40 copay after deductible
Routine Physical Exams / Well Baby Exams (Age and frequency schedules apply)	\$30 copay, deductible waived	\$20 copay, deductible waived	\$0 copay, deductible waived	\$25 copay, deductible waived
Routine GYN Exam (Limited to one exam and pap smear per 365 days.)	\$50 copay, deductible waived	\$30 copay, deductible waived	\$0 copay, deductible waived	\$40 copay, deductible waived
Durable Medical Equipment (\$2,500 Calendar Year Maximum)	50% after deductible	50% after deductible	100% after deductible	50% after deductible
Inpatient Hospital	\$500 copay per day, 5 day copay maximum per admission, after deductible	\$300 copay per day, 5 day copay maximum per admission, after deductible	\$0 copay per admission after deductible	\$400 copay per day, 5 day copay maximum per admission, after deductible
Outpatient Surgery	\$250 copay after deductible	\$150 copay after deductible	\$0 copay after deductible	\$200 copay after deductible
Emergency Room (Copay waived if admitted.)	\$100 copay after deductible	\$100 copay after deductible	\$0 copay after deductible	\$100 copay after deductible
Mental Health – Inpatient (Biologically Based: Treated the same way as any other illness. Non-Biologically Based: Max. of 30 days per calendar year.)	\$500 copay per day, 5 day copay maximum per admission, after deductible	\$300 copay per day, 5 day copay maximum per admission, after deductible	\$0 copay per admission after deductible	\$400 copay per day, 5 day copay maximum per admission, 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.)	\$500 copay per day, 5 day copay maximum per admission, after deductible	\$300 copay per day, 5 day copay maximum per admission, after deductible	\$0 copay per admission after deductible	\$400 copay per day, 5 day copay maximum per admission, after deductible
Routine Eye Exam	\$50 copay, deductible waived	\$30 copay, deductible waived	\$0 copay, deductible waived	\$40 copay, deductible waived
Glasses and Contact Lens Reimbursement	\$100/24 month period, deductible waived	\$100/24 month period, deductible waived	\$100/24 month period, deductible waived	\$100/24 month period, deductible waived
Aetna Vision Discounts ^{5M}	Included	Included	Included	Included
Prescription Drugs: 30-day supply	Option 1: \$20/\$40/\$70 after deductible Option 2: \$15/\$35/\$60 after deductible Option 3: \$15/\$25/\$40 after deductible	Option 1: \$20/\$40/\$70 after deductible Option 2: \$15/\$35/\$60 after deductible Option 3: \$15/\$25/\$40 after deductible	\$0 copay after deductible	Option 1: \$20/\$40/\$70 after deductible Option 2: \$15/\$35/\$60 after deductible Option 3: \$15/\$25/\$40 after deductible
Retail or Mail Order: 90-day supply	Option 1: \$40/\$80/\$140 after deductible Option 2: \$30/\$70/\$120 after deductible Option 3: \$30/\$50/\$80 after deductible	Option 1: \$40/\$80/\$140 after deductible Option 2: \$30/\$70/\$120 after deductible Option 3: \$30/\$50/\$80 after deductible	\$0 copay after deductible	Option 1: \$40/\$80/\$140 after deductible Option 2: \$30/\$70/\$120 after deductible Option 3: \$30/\$50/\$80 after deductible
Contraceptives and Diabetic Supplies	Included	Included	Included	Included

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 will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

³ The Individual Deductible can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

⁴ The Individual Maximum Out-of-Pocket can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Maximum Out-of-Pocket can be met by a combination of family members or by any single individual within the family. 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.

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

NOTE: For a summary of Limitations and Exclusions, refer to page 8. 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

CONSUMER DIRECTED – POS HSA-COMPATIBLE PLAN OPTIONS

Additional plans are available. Please contact your broker or Aetna.	NJ POS HSA COMPATIBLE NO-REFERRAL 1 ^{1,2}		NJ POS HSA COMPATIBLE NO-REFERRAL 2 ^{1,2}	
MEMBER BENEFITS	Network No Referral Needed	Non-Network No Referral Needed	Network No Referral Needed	Non-Network No Referral Needed
Plan Coinsurance	N/A	50% after deductible	N/A	70% after deductible
Calendar Year Deductible ³		\$2,500 individual \$5,000 family (Network and Non-Network combined.)		\$1,500 individual \$3,000 family (Network and Non-Network combined.)
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 individual \$10,000 family (Network and Non-Network combined.)		\$3,000 individual \$6,000 family (Network and Non-Network combined.)
Lifetime Maximum Benefit	Unlimited	\$5,000,000	Unlimited	\$5,000,000
Primary Physician Office Visit	\$30 copay after deductible	50% after deductible	\$20 copay after deductible	70% after deductible
Specialist Office Visit	\$50 copay after deductible	50% after deductible	\$30 copay after deductible	70% after deductible
Outpatient Services – Lab	\$50 copay after deductible	50% after deductible	\$30 copay after deductible	70% after deductible
Outpatient Services – X-Ray	\$50 copay after deductible	50% after deductible	\$30 copay after deductible	70% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 copay after deductible	50% after deductible	\$100 copay after deductible	70% after deductible
Chiropractic Services (30 visits per calendar year, Network and Non-Network combined.)	\$50 copay after deductible	50% after deductible	\$30 copay after deductible	70% after deductible
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. Network and Non-Network combined.)	\$50 copay after deductible	50% after deductible	\$30 copay after deductible	70% after deductible
Routine Physical Exams/Well Baby Exams (Age and frequency schedules apply)	\$0 copay, deductible waived	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.	\$0 copay, deductible waived	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 GYN Exam (Limited to one exam and pap smear per 365 days, Network and Non-Network combined.)	\$0 copay, deductible waived	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.	\$0 copay, deductible waived	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.
Durable Medical Equipment (\$2,500 Calendar Year Maximum, Network and Non-Network combined.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Inpatient Hospital	\$500 copay per day, 5 day copay maximum per admission, after deductible	50% after deductible	\$300 copay per day, 5 day copay maximum per admission, after deductible	70% after deductible
Outpatient Surgery	\$250 copay after deductible	50% after deductible	\$150 copay after deductible	70% after deductible
Emergency Room (Copay waived if admitted.)	\$100 copay after deductible	\$100 copay after deductible	\$100 copay after deductible	\$100 copay after deductible
Mental Health – Inpatient (Biologically Based: Treated the same way as any other illness. Non-Biologically Based: Max. of 30 days per calendar year. Network and Non-Network combined.)	\$500 copay per day, 5 day copay maximum per admission, after deductible	50% after deductible	\$300 copay per day, 5 day copay maximum per admission, after deductible	70% after deductible
Substance Abuse – Inpatient (Detox.: 30 days per calendar year. Network and Non-Network combined. Rehab.: Max. of 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 day, 5 day copay maximum per admission, after deductible	50% after deductible	\$300 copay per day, 5 day copay maximum per admission, after deductible	70% after deductible
Routine Eye Exam	\$0 copay, deductible waived	Not Covered	\$0 copay, deductible waived	Not Covered
Glasses and Contact Lens Reimbursement	\$100/24 month period, deductible waived	Not Covered	\$100/24 month period, deductible waived	Not Covered
Aetna Vision Discounts SM	Included	Not Covered	Included	Not Covered
Prescription Drugs: 30-day supply	Option 1: \$20/\$40/\$70 after deductible Option 2: \$15/\$35/\$60 after deductible Option 3: \$15/\$25/\$40 after deductible	Not Covered	Option 1: \$20/\$40/\$70 after deductible Option 2: \$15/\$35/\$60 after deductible Option 3: \$15/\$25/\$40 after deductible	Not Covered
Retail or Mail Order: 90-day supply	Option 1: \$40/\$80/\$140 after deductible Option 2: \$30/\$70/\$120 after deductible Option 3: \$30/\$50/\$80 after deductible	Not Covered	Option 1: \$40/\$80/\$140 after deductible Option 2: \$30/\$70/\$120 after deductible Option 3: \$30/\$50/\$80 after deductible	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered

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 will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

3 The Individual Deductible can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

4 The Individual Maximum Out-of-Pocket can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Maximum Out-of-Pocket can be met by a combination of family members or by any single individual within the family. 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.

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

NOTE: For a summary of Limitations and Exclusions, refer to page 8. 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

CONSUMER DIRECTED – POS HSA-COMPATIBLE PLAN OPTIONS - CONTINUED

Additional plans are available. Please contact your broker or Aetna.		NJ POS HSA COMPATIBLE NO-REFERRAL 3 1,2	
MEMBER BENEFITS	Network No Referral Required	Non-Network No Referral Required	
Plan Coinsurance	N/A	60% after deductible	
Calendar Year Deductible ³		\$2,000 individual \$4,000 family (Network and Non-Network combined.)	
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.)		\$4,000 individual \$8,000 family (Network and Non-Network combined.)	
Lifetime Maximum Benefit	Unlimited	\$5,000,000	
Primary Physician Office Visit	\$25 copay after deductible	60% after deductible	
Specialist Office Visit	\$40 copay after deductible	60% after deductible	
Outpatient Services – Lab	\$40 copay after deductible	60% after deductible	
Outpatient Services – X-Ray	\$40 copay after deductible	60% after deductible	
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 copay after deductible	60% after deductible	
Chiropractic Services (30 visits per calendar year, Network and Non-Network combined.)	\$40 copay after deductible	60% after deductible	
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. Network and Non-Network combined.)	\$40 copay after deductible	60% after deductible	
Routine Physical Exams/Well Baby Exams (Age and frequency schedules apply)	\$0 copay, deductible waived	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 GYN Exam (Limited to one exam and pap smear per 365 days, Network and Non-Network combined.)	\$0 copay, deductible waived	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.	
Durable Medical Equipment (\$2,500 Calendar Year Maximum, Network and Non-Network combined.)	50% after deductible	50% after deductible	
Inpatient Hospital	\$400 copay per day, 5 day copay maximum per admission, after deductible	60% after deductible	
Outpatient Surgery	\$200 copay after deductible	60% after deductible	
Emergency Room (Copay waived if admitted.)	\$100 copay after deductible	\$100 copay after deductible	
Mental Health – Inpatient (Biologically Based: Treated the same way as any other illness. Non-Biologically Based: Max. of 30 days per calendar year. Network and Non-Network combined.)	\$400 copay per day, 5 day copay maximum per admission, after deductible	60% after deductible	
Substance Abuse – Inpatient (Detox.: 30 days per calendar year. Network and Non-Network combined. Rehab.: Max. of 30 days per calendar year; 90 days per lifetime. Network and Non-Network combined. Alcohol abuse is treated the same as any other illness.)	\$400 copay per day, 5 day copay maximum per admission, after deductible	60% after deductible	
Routine Eye Exam	\$0 copay, deductible waived	Not Covered	
Glasses and Contact Lens Reimbursement	\$100/24 month period, deductible waived	Not Covered	
Aetna Vision Discounts ^{5M}	Included	Not Covered	
Prescription Drugs: 30-day supply	Option 1: \$20/\$40/\$70 after deductible Option 2: \$15/\$35/\$60 after deductible Option 3: \$15/\$25/\$40 after deductible	Not Covered	
Retail or Mail Order: 90-day supply	Option 1: \$40/\$80/\$140 after deductible Option 2: \$30/\$70/\$120 after deductible Option 3: \$30/\$50/\$80 after deductible	Not Covered	
Contraceptives and Diabetic Supplies	Included	Not Covered	

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 will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

3 The Individual Deductible can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

4 The Individual Maximum Out-of-Pocket can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Maximum Out-of-Pocket can be met by a combination of family members or by any single individual within the family. 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.

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

NOTE: For a summary of Limitations and Exclusions, refer to page 8. 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

CONSUMER DIRECTED – PPO BASIC HOSPITAL 5PLAN OPTION

Additional plans are available. Please contact your broker or Aetna.		NJ PPO BASIC HOSPITAL PLAN¹	
MEMBER BENEFITS	Network No Referral Needed	Non-Network No Referral Needed	
Plan Coinsurance (Applies to most services)	80% after deductible	60% after deductible	
Calendar Year Deductible ²	\$2,500 per member/\$5,000 family (Network and Non-Network combined)		
Calendar Year Maximum Out-of-Pocket ³ (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 (Network and Non-Network combined)		
Lifetime Max Benefit	Unlimited	\$5,000,000	
Primary Physician Office Visit	\$20 copay (deductible waived)	60% (deductible waived)	
	Refer to Other Provisions. Three (3) office visits per member per calendar year. Network and Non-Network combined.		
Specialist Office Visit	\$20 copay (deductible waived)	60% (deductible waived)	
	Refer to Other Provisions. Three (3) office visits per member per calendar year. Network and Non-Network combined.		
Outpatient Services (Diagnostic/X-Ray/Lab) and Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$200 benefit allowance per member per calendar year for services associated with three (3) allowed office visits. Network and Non-Network combined.		
Chiropractic Services	\$20 copay (deductible waived)	60% (deductible waived)	
	Refer to Other Provisions. Three (3) office visits per member per calendar year. Network and Non-Network combined.		
Outpatient Physical, Occupational and Speech Therapy	\$20 copay (deductible waived)	60% (deductible waived)	
	Refer to Other Provisions. Three (3) office visits per member per calendar year. Network and Non-Network combined.		
Durable Medical Equipment	Not Covered	Not Covered	
Inpatient Hospital	80% after deductible	60% after deductible	
Outpatient Surgery	80% after deductible for facility-based surgery; surgery in physician's office is not covered.	60% after deductible for facility-based surgery; surgery in physician's office is not covered.	
Emergency Room (Copay waived if admitted)	80% after deductible	80% after deductible	
Mental Health – Inpatient (Biologically Based: Treated the same way as any other illness; Non-Biologically Based: Max. of 30 days per calendar year. Network and Non-Network combined.)	80% after deductible	60% after deductible	
Substance Abuse – Inpatient (Drug Abuse Detox.: Max of 30 days per calendar year. Network and Non-Network combined. Drug Abuse Rehab.: Max of 30 days per calendar year; 90 days per lifetime. Network and Non-Network combined. Alcohol Abuse is treated the same as any other illness.)	80% after deductible	60% after deductible	
Prescription Drugs	Rx Discount Network Card	Not Covered	
Contraceptives and Diabetic Supplies	Included	Not Covered	
Other Provisions	Three (3) office visits per member per calendar year combined for primary physician office visits, specialist office visits, preventive care, chiropractic care and outpatient physical, occupational and speech therapy. Network and Non-Network combined.		

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 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.

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 8. 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

CONSUMER DIRECTED – PPO FIRST DOLLAR PLAN OPTION

Additional plans are available. Please contact your broker or Aetna.		NJ PPO FIRST DOLLAR PLAN¹	
MEMBER BENEFITS	Network No Referral Needed	Non-Network No Referral Needed	
Health Fund	First \$500 per member (\$1,000 Family) in benefits (excluding member cost-sharing for prescription drug benefits) for Network and Non-Network benefits is paid at 100%, not subject to the deductible. After \$500 per member (\$1,000 Family) in benefits, the deductible applies for all covered services, except member cost-sharing for prescription drug benefits, preventive care (Network only), newborn hearing screenings, immunizations and blood lead services for lead poisoned children (which includes testing, medical evaluation and any necessary medical follow-up and treatment). After the deductible is met, coinsurance and/or copay apply. There is no rollover feature.		
Plan Coinsurance (Applies to most services)	80% after deductible	60% after deductible	
Calendar Year Deductible ²	\$1,500 per member/\$3,000 family (Network and Non-Network combined)		
Calendar Year Maximum Out-of-Pocket ³ (All amounts paid as deductible, copayment and coinsurance for covered services and supplies will apply toward the Maximum Out-of-Pocket)	\$4,000 per member/\$8,000 family (Network and Non-Network combined)		
Lifetime Max Benefit	Unlimited	\$5,000,000	
Primary Physician Office Visit	\$20 copay after deductible	60% after deductible	
Specialist Office Visit	\$40 copay after deductible	60% after deductible	
Outpatient Services – Lab	\$40 copay after deductible	60% after deductible	
Outpatient Services – X-Ray	\$40 copay after deductible	60% after deductible	
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80% after deductible	60% after deductible	
Chiropractic Services	\$40 copay after deductible	60% after deductible	
	Limited to 30 visits per calendar year. Network and Non-Network combined.		
Outpatient Physical, Occupational and Speech Therapy	\$40 copay after deductible	60% after deductible	
	Cognitive and speech therapy (combined) 30 visits per calendar year; occupational and physical therapy (combined) 30 visits per calendar year. Network and Non-Network combined.		
Routine Adult Physical Exams (Age and frequency schedules apply.)	\$20 copay, deductible waived	60% after deductible	
Well Child Exams (Age and frequency schedules apply.)	\$20 copay, deductible waived	60% after deductible, except deductible waived for immunizations.	
Routine GYN Exam (Limited to one routine exam and pap smear per calendar year.)	\$40 copay, deductible waived	60% after deductible	
Durable Medical Equipment	50% after deductible	50% after deductible	
	\$2,500 calendar year max. Network and Non-Network combined.		
Inpatient Hospital	80% after deductible	60% after deductible	
Outpatient Surgery	80% after deductible	60% after deductible	
Emergency Room (Copay waived if admitted)	\$100 plus 80% after deductible	\$100 plus 80% after deductible	
Mental Health – Inpatient (Biologically Based: Treated the same way as any other illness; Non-Biologically Based: Max. of 30 days per calendar year. Network and Non-Network combined.)	80% after deductible	60% after deductible	
Substance Abuse – Inpatient (Drug Abuse Detox.: Max of 30 days per calendar year. Network and Non-Network combined. Drug Abuse Rehab.: Max of 30 days per calendar year; 90 days per lifetime. Network and Non-Network combined. Alcohol Abuse is treated the same as any other illness.)	80% after deductible	60% after deductible	
Prescription Drugs: 30 day supply	\$15/\$25/\$40	\$15/\$25/\$40	
Retail or Mail Order: 90-day supply	\$30/\$50/\$80	\$30/\$50/\$80	
Contraceptives and Diabetic Supplies	Included	Included	

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 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.

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 8. 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

CONSUMER DIRECTED – PPO HSA-COMPATIBLE PLAN OPTIONS

Additional plans are available. Please contact your broker or Aetna.		NJ PPO HSA-COMPATIBLE PLAN 1 ¹		NJ PPO HSA-COMPATIBLE PLAN 2 ¹	
MEMBER BENEFITS	Network No Referral Needed	Non-Network No Referral Needed	Network No Referral Needed	Non-Network No Referral Needed	
Plan Coinsurance (Applies to most services)	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Calendar Year Deductible ² (All covered prescription drug and medical expenses, except preventive care services, which include newborn hearing screenings and immunizations, apply to the deductible)	\$2,500 per member/\$5,000 family (Network and Non-Network combined)		\$2,500 per member/\$5,000 family (Network and Non-Network combined)		
Calendar Year Maximum Out-of-Pocket ³ (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 (Network and Non-Network combined)		\$2,500 per member/\$5,000 family (Network and Non-Network combined)		
Lifetime Maximum Benefit	Unlimited	\$5,000,000	Unlimited	\$5,000,000	
Primary Physician Office Visit (Except for routine care listed below)	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Specialist Office Visit	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Outpatient Services – Lab	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Outpatient Services – X-Ray	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Chiropractic Care (Limited to 30 visits per calendar year, Network and Non-Network combined.)	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Outpatient Physical, Occupational, Speech Therapy (Cognitive and speech therapy (combined) 30 visits per calendar year; occupational and physical therapy (combined) 30 visits per calendar year. Network and Non-Network combined.)	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Routine Physical Exams — Adults (Age and frequency schedules apply)	\$10 copay (deductible waived)	70% (deductible waived)	100% (deductible waived)	80% (deductible waived)	
Well Baby Exams (Age and frequency schedules apply)	\$10 copay (deductible waived)	70% (deductible waived)	100% (deductible waived)	80% (deductible waived)	
Routine GYN Exam (Limited to one annual exam and pap smear, Network and Non-Network combined)	\$20 copay (deductible waived)	70% (deductible waived)	100% (deductible waived)	80% (deductible waived)	
Durable Medical Equipment (\$2,500 Calendar Year Maximum, Network and Non-Network combined)	50% after deductible	50% after deductible	50% after deductible	50% after deductible	
Inpatient Hospital	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Outpatient Surgery	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Emergency Room (Copay waived if admitted)	\$100 copay plus 90% after deductible	\$100 copay plus 90% after deductible	\$100 copay after deductible	\$100 copay after deductible	
Mental Health – Inpatient (Biologically Based: Treated the same way as any other illness. Non-Biologically Based: Max. of 30 days per calendar year. Network and Non-Network combined.)	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Substance Abuse – Inpatient (Drug Abuse Detox.: Max of 30 days per calendar year. Network and Non-Network combined. Drug Abuse Rehab.: Max of 30 days per calendar year; 90 days per lifetime. Network and Non-Network combined. Alcohol Abuse is treated the same as any other illness.)	90% after deductible	70% after deductible	100% after deductible	80% after deductible	
Prescription Drugs: 30-day supply	\$15/\$25/\$40 after deductible	\$15/\$25/\$40 after deductible	\$0 copay after deductible	\$0 copay after deductible	
Retail or Mail Order: 90-day supply	\$30/\$50/\$80 after deductible	\$30/\$50/\$80 after deductible	\$0 copay after deductible	\$0 copay after deductible	
Contraceptives and Diabetic Supplies	Included	Included	Included	Included	

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 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.

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 8. 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

HMO/POS/PPO HSA Compatible and PPO First Dollar Plans

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.
- For the PPO HSA-Compatible and PPO First Dollar Plans: Weight control services, including surgical procedures, medical treatment, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications, food or food supplements, except as provided for in the Food Products for Inherited Metabolic Disease provision, 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.

PPO Basic Hospital Plan

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.
- Orthotics.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.
- Weight control services, including surgical procedures, medical treatment, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications, food or food supplements, except as provided for in the Food Products for Inherited Metabolic Disease provision, 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.

HMO/POS/PPO HSA-Compatible, PPO First Dollar and PPO Basic Hospital 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 for HMO/POS products or 1-800-80-AETNA for Traditional/PPO products if assistance is needed in obtaining a Certificate of Creditable Coverage from prior carriers or with any questions on the information noted above.

Notes

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.

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.

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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