Aetna

PATRIOT X

MT. HOLLY TWP. BOE
Proposed effective date: 07-01-2008
QPOS® - New Jersey

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Deductible (per calendar year)	None Individual None Family	$200 Individual $400 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable.		
Member Coinsurance	Covered 100%	20%
Out-of-Pocket Maximum (per calendar year)	None Individual None Family	$1,000 Individual $2,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum Only those participating providers/referred and non-participating providers/participating providers self referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required	Not applicable
Precertification Requirement Certain participating provider self-referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care physicians services, except direct access services.	None

PREVENTIVE CARE	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Routine Adult Physical Exams/ Immunizations (Age and frequency schedules apply)	$15 copay	Covered 100%
Well Child Exams / Immunizations (Age and frequency schedules apply) includes coverage for blood lead level screenings.	$15 copay	Covered 100%
Routine Gynecological Care Exams Includes routine tests and related lab fees. Direct access to participating providers without a referral.	$15 copay One routine exam per 365 days.	Covered 100%
Routine Mammograms	$25 copay	Covered 100%
One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over. Direct access to participating providers without a referral		
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.		
Routine Eye Exam Age/Frequency Schedule may apply.	$25 copay; copay not to exceed $30	Not Covered

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Direct access to participating providers without a referral		
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing; copay not to exceed $30.	Not Covered
Newborn Hearing Testing and Monitoring	Subject to Routine Physical Exam cost sharing; copay not to exceed $30.	20%; deductible waived
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Office Visits to member's selected Primary Care Physician	Office Hours : $15 copay After Office Hours/Home : $20 copay	20%
Specialist Office Visits	$25 copay	20%
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.		
Maternity OB Visits	$25 copay; for initial visit only, thereafter covered 100%	20%
Allergy Treatment	Same as applicable participating provider office visit member cost sharing	20%
Allergy Testing	Same as applicable participating provider office visit member cost sharing	20%
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Diagnostic Laboratory	$25 copay	Covered 100%
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 cost sharing.		
Diagnostic X-ray	$25 copay	Covered 100%
Outpatient hospital or other Outpatient facility		
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Emergency Room	$50 copay	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	100% covered	Refer to participating provider benefit.
HOSPITAL CARE	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Inpatient Coverage	Covered 100%	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	Covered 100%	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	Covered 100%	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**

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Inpatient Biologically Based Mental Illness	Covered 100%	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Biologically Based Mental Illness	Covered 100% Limited to 35 days per calendar year	Covered 100% Limited to 35 days per calendar year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based Mental Illness	$25 per visit copay	20% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based Mental Illness	$25 per visit copay Limited to 20 visits per calendar year	20% per visit Limited to 20 visits per calendar year
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Inpatient Detoxification - Alcohol Abuse	Covered 100%	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Detoxification - Drug Abuse	Covered 100%	Covered 100%; 7 days per admission, 4 admissions per lifetime.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification - Alcohol Abuse	$25 per visit copay	20% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Detoxification - Drug Abuse	$25 per visit copay	20% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation - Alcohol Abuse	Covered 100%	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Rehabilitation - Drug Abuse	Covered 100% Limited to 30 days per calendar year	Covered 100% 30 days per cal yr, 90 days lifetime
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Rehabilitation - Alcohol Abuse	$25 per visit copay	20% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Rehabilitation - Drug Abuse	$25 per visit copay Limited to 20 visits per 365 days.	20% per visit 20 visits per cal yr, 120 visits lifetime
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Skilled Nursing Facility	Covered 100% Limited to 100 days per calendar year.	Covered 100% Limited to 100 days per calendar year.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100%	Covered 100% Limited to 60 visits per calendar year
Limited to 1 intermittent visit per day by a non-participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 100%	20% per admission ($10,000 lifetime maximum combined inpatient and outpatient care.)
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

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Hospice Care - Outpatient	Covered 100%	20% per visit ($10,000 lifetime maximum combined inpatient and outpatient care.)
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy)	$25 per visit copay	20% per visit
Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.		
Subluxation	$25 per visit copay Limited to 20 visits per calendar year	20% per visit
Durable Medical Equipment	Not Covered	50% (must pre-certify if over $1,500) Must Precertify if over $1,500
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies	20%
Dental	Pediatric Preventive Dental, $15 copay	Not Covered
Vision Eyewear	$70 once per 24 month period	Referred to participating provider benefit.
Transplants	Covered 100%	20% per admission
Bariatric	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
FAMILY PLANNING	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Infertility Treatment Diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Comprehensive Infertility Services Coverage includes Artificial Insemination and Ovulation Induction.	Applicable copay applies	20%
Advanced Reproductive Technology (ART)	Covered 100%	20%
ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery.		
Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing
Pharmacy services are not applied to the medical deductible		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 23.	

Exclusions and Limitations

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits include Aetna Health Inc. and Aetna Health Insurance Company. While this material is believed to be accurate as of the print date, it is subject to change.

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.* However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

- 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.
- Durable medical equipment.
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial).
- Hearing aids.
- Home births
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs.
- Nonmedically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.

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 document (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate and/or Group Policy) 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. With the exception of Aetna Rx Home Delivery, all participating 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.

Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC. If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your 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 precertification and step-therapy, please refer to Aetna's website at www.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 your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your 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.

Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by a non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage.

Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification), inpatient and outpatient rehabilitation). When the Member obtains covered services from participating providers, the provider will obtain precertification. If the Member obtains covered services from a nonparticipating provider, the Member must obtain the precertification. Precertification requirements may vary. Members may refer to their plan documents for a complete list of medical services that require precertification. Certain benefits like comprehensive infertility and advanced reproductive technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.