ENGINEERING RESOURCE GROUP, INC.
Proposed effective date: 11-01-2010
AETNA CHOICE™ POS - New Jersey

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

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year)	None Individual None Family	$5,000 Individual $15,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Out-of-Pocket Maximum (per calendar year)	$5,000 Individual $10,000 Family	$30,000 Individual $90,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers and non-participating providers 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 unless otherwise indicated.	Unlimited unless otherwise indicated.
Payment for Non-Preferred	Not Applicable	Professional: 110% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Not Required	Not Applicable
Precertification Requirement Certain non-participating providers/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	None	None
PREVENTIVE CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	Covered 100%	Not Covered
Well Child Exams / Immunizations (Age and frequency schedules apply) Includes coverage for blood level screenings. Includes coverage for blood level screenings.	Covered 100%	Not Covered
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One exam per calendar year.	Covered 100%	Not Covered
Routine Mammograms	Covered 100%	50% after deductible
One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over		
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over	Covered 100%.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Colorectal Cancer Screening	Covered 100%.	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.		

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

Routine Eye Exam Age/Frequency Schedule may apply.	Covered 100%	Not Covered
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing	Subject to Routine Physical Exam benefit
Newborn Hearing Testing and Monitoring	Subject to Routine Physical Exam cost sharing	50%; deductible waived
Hearing Aids	$30 Copay	50%; after deductible
Coverage for all persons age 15 or younger. One hearing aid for each impaired ear limited to $1,000 per hearing aid every 24 months.		
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Primary Care Physician Visits	Office Hours: $30 copayand After Office Hours/Home: $35 copay	50% after deductible
Specialist Office Visits	$50 copay	50% after deductible
Maternity OB Visits	$50 copay for initial visit only, thereafter covered 100%	50% after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing	50% after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing	50% after deductible
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Diagnostic Laboratory	Covered 100%	50% after deductible
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 Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	$50 copay	50% after deductible
Diagnostic X-ray for Complex Imaging Services	20%	50% after deductible
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Emergency Room	20%	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	Refer to participating provider benefit.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Coverage	$500 per day for the first 5 days per admission, thereafter Covered 100%	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	$500 per day for the first 5 days per admission, thereafter Covered 100%	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

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

Outpatient Surgery Performed at a Hospital Outpatient Facility Performed at an Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	$500 copay per visit	50% per visit; after deductible $2,000 calendar year maximum
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Biologically Based Mental Illness	$500 per day for the first 5 days per admission, thereafter Covered 100%	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Biologically Based Mental Illness	$500 per day for the first 5 days per admission, thereafter Covered 100%	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based Mental Illness	$50 copay per visit	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based Mental Illness	$50 copay per visit	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Detoxification- Alcohol Abuse	$500 per day for the first 5 days per admission, thereafter covered 100%	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification-Alcohol Abuse	$50 copay	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Detoxification-Drug Abuse	$50 copay	50%; after deductible
Inpatient Rehabilitation - Alcohol Abuse	$500 per day for the first 5 days per admission, thereafter covered 100%	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Rehabilitation - Drug Abuse	$500 per day for the first 5 days per admission, thereafter covered 100%[	50% per admission; after deductible
. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	$500 per day for the first 5 days per admission, thereafter covered 100%	50%
Outpatient Rehabilitation - Alcohol Abuse	$50 Copay	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Rehabilitation - Drug Abuse	$50 Copay	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

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

OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Skilled Nursing Facility	$500 per day for the first 5 days per admission, thereafter Covered 100%	50% per visit; after deductible
	Limited to 60 days per calendar year	Limited to 60 days per calendar year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	$50 copay	50% per visit; after deductible
Hospice Care - Inpatient	$500 per day for the first 5 days per admission, thereafter Covered 100%	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	$50 copay	50% per admission; after deductible
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)	$50 copay	50% per admission; after deductible
	Limited to 60 visits per calendar year.	Limited to 60 visits per calendar year.
Subluxation	$50 copay Limited to 20 visits per calendar year	50% after deductible $1,000 calendar year maximum.
Durable Medical Equipment	50%	50% (must precertify if over $1,500)
	Limited to $2,500 per calendar year	Limited to $2,500 per calendar year
Prosthetics	$30 Copay; after deductible	Covered according to standard claim practice
Orthotics	$30 Copay; after deductible	Covered according to standard claim practice
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	50%
Dental	Not Covered	Not Covered
Vision Eyewear	$100 once per 24 month period	Covered same as participating provider benefit
Transplants	$500 per day for the first 5 days per admission, thereafter Covered 100%	50% per admission; after deductible
	Coverage is provided at an IOE contracted facility only	Coverage is provided at an Non-IOE contracted facility only
Bariatric Surgery	$500 per day for the first 5 days per admission, thereafter coverage is provided at 100%	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

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

FAMILY PLANNING	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Infertility Treatment	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; after deductible.
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Applicable copay applies	50%
Coverage includes Artificial Insemination and Ovulation Induction.		
Advanced Reproductive Technology (ART)	Covered 100%	50%
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, limited to 4 complete egg retrievals per lifetime.		
Voluntary Sterilization	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing
Including tubal ligation and vasectomy.		
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Retail	$15 copay for formulary generic drugs, $35 copay for formulary brand-name drugs, and $60 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
(2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be doubled)		
Mail Order	$30 copay for formulary generic drugs, $70 copay for formulary brand-name drugs, and $120 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered
No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.		
Dependents Eligibility	Spouse, children from birth to age 26.	

For any service or supply that is subject to a maximum visit, day, or dollar limitation, such maximums will be reduced by any services or supplies which are covered as participating providers and non-participating providers benefits under this plan.

Exclusions and Limitations
Plans are provided by Aetna Health Inc. and Aetna Health Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

The following is a 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 by your employer.

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

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval.
• 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, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically 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.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, 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.

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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si necesita asistencia linguistica de un representante de Aetna, contamos con una linea directa de Servicios a Miembros disponible en varios idiomas. Comuniquese al 1-888-982-3862 (140 idiomas disponibles. Debe solicitar un interprete). TDD 1-800-628-3323 (para personas con problemas de audicion unicamente).

Plan features and availability may vary by location and group size.