



Customer Name
 NJ HNOption HSA 6 (10/10)
 Proposed effective date: xx-xx-xxxx
 Aetna Health Network OptionSM - New Jersey
 Qualified High Deductible Health Plan

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)	\$2,500 Employee \$5,000 Family	\$5,000 Employee \$15,000 Family
<p>Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services, 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. There is no Individual Deductible to satisfy within the Family Deductible.</p>		
Out-of-Pocket Maximum (per calendar year)	\$5,000 Employee \$10,000 Family	\$30,000 Employee \$90,000 Family
<p>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 deductibles, coinsurance percentage and copays (except any penalty amounts) 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. There is no Individual Out-of-Pocket Maximum to satisfy within the Family Out-of-Pocket Maximum.</p>		
Lifetime Maximum	Unlimited	Unlimited
Payment for services from a Non-Participating Provider*	Not Applicable	Professional: 110% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Not Required	Not Applicable
<p>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.</p>		
Referral Requirements	None	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations 1 exam every 12 months.	Covered 100%; deductible waived	50%; after deductible
Well Child Exams / Immunizations (Age and frequency schedules apply) Includes coverage for blood level screenings.	Covered 100%; deductible waived	50%; deductible waived
Routine Gynecological Care Exams Includes Pap smear and related lab fees.	Covered 100%; deductible waived One exam per 365 days.	50%; after deductible One exam per 365 days.
Routine Mammograms Recommended: one baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males 40 and over.	Covered 100%; deductible waived	50%; after deductible
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.	Covered 100%; deductible waived	50%; after deductible



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Routine Eye Exam Age/Frequency Schedule may apply.	Covered 100%; deductible waived	50%; after deductible
Routine Hearing Screening	Subject to Routine Physical Exam benefit.	Subject to Routine Physical Exam benefit.
Newborn Hearing Testing and Monitoring	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	50%; deductible waived
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	Office Hours: 10%; after deductible After Office Hours/Home: 10%; after deductible	50%; after deductible
Specialist Office Visits	10%; after deductible	50%; after deductible
Prenatal OB Care	10%; after deductible	50%; after deductible
E-visit to PCP An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	10%; after deductible	50%; after deductible
E-visit to Specialist An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	10%; after deductible	50%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	10%; after deductible	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 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.	10%; after deductible	50%; after deductible
Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	10%; after deductible	50%; after deductible
Diagnostic X-ray for Complex Imaging Services	20%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Emergency Room	20%; after deductible	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%; after deductible	Refer to participating provider benefit.



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Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE		
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Coverage	10% per admission; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	10% per admission; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery		
Performed at a Hospital Outpatient Facility	10% per visit; after deductible	50% per visit; after deductible
Performed at an Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	10% per visit; after deductible	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	10% per admission; after deductible	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	10% per admission; after deductible	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	10% per visit; after deductible	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based Mental Illness	10% per visit; after deductible	50% per visit; 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	10% per admission; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Detoxification- Drug Abuse	10% per admission; after deductible	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	10% per visit; after deductible	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Detoxification-Drug Abuse	10% per visit; after deductible	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation - Alcohol Abuse	10% per admission; after deductible	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	10% per admission; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	10%; after deductible	50%; after deductible
Outpatient Rehabilitation - Alcohol Abuse	10% per visit; after deductible	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		



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Outpatient Rehabilitation - Drug Abuse	10% per visit; after deductible	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Skilled Nursing Facility	10% per admission; after deductible Limited to 60 days per calendar year	50% per admission; after deductible 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	10% per visit; after deductible Limited to 60 visits per calendar year	50% per visit; after deductible Limited to 60 visits per calendar year
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	10% per admission; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	10% per visit; after deductible	50% per visit; 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)	10% per visit; after deductible Limited to 60 visits per calendar year.	50%; after deductible Limited to 60 visits per calendar year.
Spinal Manipulation	10% per visit; after deductible Limited to 20 visits per calendar year	50% per visit; after deductible \$1,000 calendar year maximum.
Durable Medical Equipment	50%; after deductible \$2,500 calendar year maximum.	50%; after deductible (must precertify if over \$1,500) \$2,500 calendar year maximum.
Prosthetics	10%; after deductible	Covered according to standard claim practice
Orthotics	10%; 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%; after deductible
Vision Eyewear	\$100 once per 24 month period	Covered same as participating provider benefit
Transplants	Covered same as any other expense for treatment in an approved IOE transplant facility. Services rendered by a participating Aetna facility, but not an IOE transplant facility, covered at out of network level.	Services rendered at a non-IOE transplant facility covered same as any other expense.
Bariatric Surgery	10% per admission; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		



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FAMILY PLANNING	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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.	10%; after deductible	50%; after deductible
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, limited to 4 complete egg retrievals per lifetime.	10%; after deductible	50%; after deductible
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Subject to applicable service type member cost sharing
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Retail (2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be doubled)	\$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
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.
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy.
 Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).

*We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate.



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Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you *choose* to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits and you should contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

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.

Investment services are independently offered through JPMorgan Institutional Investors, Inc., a subsidiary of JPMorgan Chase Bank.

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.



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- 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-98-AETNA (1-888-982-3862)**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-98-AETNA (1-888-982-3862)**.

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

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



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