



PLAN DESIGN & BENEFITS
 ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Deductible (per calendar year)	\$4,000 Individual \$8,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. 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.	
Member Coinsurance	20%
Applies to all expenses unless otherwise stated	
Payment Limit (per calendar year)	\$5,000 Individual \$10,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and prescription drug copays (except any penalty amounts) may be used to satisfy the Payment Limit Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year. There is no Individual Payment Limit to satisfy within the Family Payment Limit.	
Lifetime Maximum	None
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	PREFERRED CARE
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months	Covered 100%; deductible waived
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the next 12 months; 1 exam per 12 months thereafter to age 18	Covered 100%; deductible waived
Routine Gynecological Care Exams Includes routine tests and related lab fees	Covered 100%; deductible waived
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
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over	Covered 100%; deductible waived
Colorectal Cancer Screening For all members age 50 and over	Covered 100%; deductible waived
Routine Eye Exams 1 routine exam per 12 months	Covered 80% after deductible
Routine Hearing Exams	Covered 80% after deductible
PHYSICIAN SERVICES	PREFERRED CARE
Primary Care Physician Office Visits	Covered 80% after deductible
Specialist Office Visits	Covered 80% after deductible
Allergy Testing	Covered 80% after deductible
Allergy Injections	Covered 80% after deductible
DIAGNOSTIC PROCEDURES	PREFERRED CARE
Diagnostic Laboratory and X-ray	Covered 80% after deductible
EMERGENCY MEDICAL CARE	PREFERRED CARE
Urgent Care Provider	Covered 80% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	Covered 80% after deductible
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 80% after deductible



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HOSPITAL CARE		PREFERRED CARE	
Inpatient Coverage		Covered 80% after deductible	
Inpatient Maternity Coverage		Covered 80% after deductible	
Outpatient Surgery		Covered 80% after deductible	
Outpatient Hospital Expenses		Covered 80% after deductible	
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit			
MENTAL HEALTH SERVICES		PREFERRED CARE	
Inpatient Biologically Based Mental Illness		Covered 80% after deductible	
Inpatient Non-Biologically Based Mental Illness		Covered 80% after deductible	
Limited to 35 days per calendar year			
Outpatient Biologically Based Mental Illness		Covered 80% after deductible	
Outpatient Non-Biologically Based Mental Illness		Covered 80% after deductible	
Limited to 30 visits per calendar year			
ALCOHOL/DRUG ABUSE SERVICES		PREFERRED CARE	
Inpatient Detoxification		Covered 80% after deductible	
Outpatient Detoxification		Covered 80% after deductible	
Inpatient Rehabilitation		Covered 80% after deductible	
Limited to 28 days per occurrence			
Outpatient Rehabilitation		Covered 80% after deductible	
OTHER SERVICES		PREFERRED CARE	
Skilled Nursing Facility		Covered 80% after deductible	
Limited to 120 days per calendar year			
Home Health Care		Covered 80% after deductible	
Hospice Care - Inpatient		Covered 80% after deductible	
Hospice Care - Outpatient		Covered 80% after deductible	
Outpatient Short-Term Rehabilitation		Covered 80% after deductible	
Include Speech, Physical, and Occupational Therapy			
Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment			
Spinal Manipulation Therapy		Covered 80% after deductible	
Limited to 20 visits per calendar year			
Durable Medical Equipment		Covered 80% after deductible	
Hearing Aids		\$1000 per ear every 24 months, maximum of \$2000	
Covered through age 15 in accordance with Grace's Law			
Transplants	Coverage is provided at an IOE contracted facility only	Covered 80% after deductible	
Bariatric Surgery		Covered 80% after deductible	
FAMILY PLANNING		PREFERRED CARE	
Infertility Treatment		Covered in accordance with the State of NJ Infertility Mandate	
GENERAL PROVISIONS			
Dependents Eligibility		Spouse, children from birth to age 26	

Exclusions and Limitations

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent.

Some benefits are subject to limitations or visit maximums. 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



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Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

Plans are administered by Aetna Life Insurance Company.