PLAN DESIGN

Customer Name: Moorestown Township Board of Education - **Retiree**

Proposed Effective Date: 04-01-2013

Plan: HMO - **Former SEHBP Aetna HMO/Horizon HMO with Rx $6/$12/$25**

Location(s): New Jersey

Prepared: 02/07/2013

PLAN DESIGN & BENEFITS
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PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	None Individual None Family
Out-of-Pocket Maximum (per calendar year)	None Individual None Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. In-Network expenses include coinsurance/copays and deductibles. Pharmacy expenses do not apply towards the Out-of-Pocket-Maximum.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 visit every 12 months	Covered 100%
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%
Routine Gynecological Care Exams Includes routine tests and related lab fees.	Covered 100%
Routine Mammograms Recommended: one baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%
Women's Health Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%
Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies.	Covered 100%
Routine Eye Exams Direct access to participating providers without a referral.	Covered 100%, after $10 per visit 1 routine exam per 12 months.
Routine Hearing Screening	Covered 100%
Newborn Hearing Testing and Monitoring	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	Office Hours: $10 copay

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Specialist Office Visits	$10 copay
Pre-Natal Maternity	Covered 100%
Allergy Treatment	$10 Copay
Allergy Testing	$10 copay
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic Laboratory	Covered 100%
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Diagnostic X-ray	Covered 100%
Outpatient hospital or other Outpatient facility (other than Complex Imaging Services)	
Diagnostic X-ray for Complex Imaging Services	Covered 100%
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	Covered 100%, $35 copay (reimbursed if service for emergency)
Emergency Room	Covered 100%, after $35 copay (waived if admitted)
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage (Including surgery and anesthesia).	Covered 100%
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%
Outpatient Hospital/Facility (Including surgery and anesthesia. Includes therapies such as Chemo/ Radiation/ Infusion)	Covered 100%
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient Mental Illness	Covered 100%
Inpatient Biologically Based Mental Illness	Covered 100%
Outpatient Mental Illness	Covered 100%

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Outpatient Biologically Based Mental Illness	Covered 100%
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**
Inpatient Detoxification - Alcohol Abuse	Covered 100%
Inpatient Detoxification - Drug Abuse	Covered 100%
Outpatient Detoxification - Alcohol Abuse	Covered 100%
Outpatient Detoxification - Drug Abuse	Covered 100%
Inpatient Rehabilitation - Alcohol Abuse	Covered 100%
Inpatient Rehabilitation - Drug Abuse	Covered 100%
Residential Treatment Facility	Covered 100%
Outpatient Rehabilitation - Alcohol Abuse	Covered 100%
Outpatient Rehabilitation - Drug Abuse	Covered 100%
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	Covered 100% Limited to 120 days; per calendar year
Home Health Care	Covered 100%
Hospice Care - Inpatient	Covered 100%
Hospice Care - Outpatient	Covered 100%
Outpatient Rehabilitation Therapy	$10 per visit Limited to 60 visits; per calendar year
Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$10 copay Limited to 20 visits; per calendar year
Autism	$10 copay
Eligible individuals to age 21 covered same as any other expense. Physical, Occupational, and Speech Therapies are covered same as any other expense with no visit limitations.	
Durable Medical Equipment	Covered 100%
Prosthetics	Covered 100%
Covered 100%	Covered 100%

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Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Generic FDA-approved Women's Contraceptives	Covered 100%
Hearing Aids	Covered 100%
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.	
Vision Eyewear	Covered 100% up to $100 every 24 months.
Bariatric Surgery	Covered 100%
Transplants	Covered 100%
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	$10 office visit copay. Inpatient hospital and outpatient facility, 100%.
Diagnosis and treatment of the underlying medical condition.	
Comprehensive Infertility Services	$10 office visit copay. Inpatient hospital and outpatient facility, 100%.
Comprehensive Infertility includes Artificial Insemination and Ovulation Induction.	
Advanced Reproductive Technology (ART)	$10 office visit copay. Inpatient hospital and outpatient facility, 100%.
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.	
Vasectomy	$10 office visit copay. Inpatient hospital and outpatient facility, 100%.
Tubal Ligation	Covered 100%
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Retail	$6 copay for formulary generic drugs, $12 copay for formulary brand-name drugs, and $25 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies. $12 copay for formulary generic drugs, $24 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name and generic drugs up to a 31-60 day supply at participating pharmacies. $18 copay for formulary generic drugs, $36 copay for formulary brand-name drugs, and $75 copay for non-formulary brand-name and generic drugs up to a 61-90 day supply at participating pharmacies.
2 times retail copay for 31-90 day supply at participating pharmacies.	

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Mail Order	$5 copay for formulary generic drugs, $18 copay for formulary brand-name drugs, and $30 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.
Prescription Drug - Out-of-Pocket Maximum per calendar year:	$ 1,322 per person
Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay.	
Plan Includes: Diabetic supplies and 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). Precert included with 90 day Transition of Care Formulary generic FDA - approved Women's Contraceptives covered 100% in network	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits 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.

• 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.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.

• 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.
• Therapy or rehabilitation other than those listed as covered.

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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 and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy 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 pharmacies' 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 the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante de Aetna que hable su idioma, por favor llame al nъmero de Servicios al Miembro que aparece en su tarjeta de identificaciyn y se le comunicarб con la lнnea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intйrprete). TDD-1-800-628-3323 (sylo para las personas con impedimentos auditivos).

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

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.

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