PLAN DESIGN

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

Proposed Effective Date: 04-01-2013

Plan: Managed Choice POS (Open Access) Plan - **Former SEHBP NJ Direct 10/Aetna Freedom 10 with Rx $10/$20/$40**

Location(s): New Jersey

Prepared: 02/07/2013

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY – INSURED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None Individual None Family	$100 Individual $250 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance	10%	20%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$400 Individual $1,000 Family	$2,000 Individual $5,000 Family
Preferred covered expenses accumulate simultaneously toward both the preferred and the non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those preferred/non-preferred out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and medical copays (except penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 or 50% of the scheduled benefit amount per occurrence, whichever is less.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months	Covered 100%	20%; after deductible
Routine Well Child Exams/Immunizations (Age and frequency schedules apply) Includes coverage for blood lead level screenings.	Covered 100%	20%; after deductible
Routine Gynecological Care Exams Includes routine tests and related lab fees.	Covered 100%	20%; after deductible
Routine Mammograms	Covered 100%	20%; after deductible
One baseline mammogram for covered females age 35-39, no frequency limit for routine mammograms for covered females age 40 and over.		
Women's Health	Covered 100%	20%; after deductible

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.

Routine Digital Rectal Exam For covered males age 40 and over.	Covered 100%	20%; after deductible
Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%	20%; after deductible
Colorectal Cancer Screening For all members age 50 and over. Coverage includes Sigmoidoscopy every 5 years for all covered members age 45 and over.	Covered 100%	20%; after deductible
Routine Eye Exams 1 routine exam per 12 months. Includes glaucoma test every 5 years for all covered members age 35 and over.	Covered 100%	20%; after deductible
Routine Hearing Exams	Covered 100%	Not Covered
Newborn Hearing Testing and Monitoring	Covered 100%	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$10 office visit copay	20%; after deductible
Specialist Office Visits	$10 office visit copay	20%; after deductible
Pre-Natal Maternity	Covered 100%	20%; 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.	Covered 100%	20%; 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.	Covered 100%	20%; 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.	Covered 100%	20%; after deductible
Allergy Testing	$10 office visit copay	20%; after deductible
Allergy Injections	Covered 100%	20%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray 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.	Covered 100%	20%; after deductible
Diagnostic Laboratory 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.	Covered 100%	20%; after deductible
Diagnostic Outpatient Complex Imaging	Covered 100%	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Emergency Room	Covered 100% after $25 copay. Copay waived if admitted.	Covered 100% after $25 copay. Copay waived if admitted.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered

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Emergency Use of Ambulance	10%	10% (emergency); 20% after deductible (necessary medical transport)
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%	20%; after deductible
Outpatient Hospital Expenses	Covered 100%	20%; after deductible
Outpatient Surgery	Covered 100%	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	20% per admission; after deductible
Outpatient	Covered 100%	20% per visit; after deductible
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	20% per admission; after deductible
Residential Treatment Facility	Covered 100%	20%; after deductible
Outpatient	Covered 100%	20% per visit; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility Limited to120 days per calendar year.	Covered 100%	20%; after deductible
Home Health Care	Covered 100%	20%; after deductible
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	Covered 100%	20%; after deductible
Hospice Care - Outpatient	Covered 100%	20%; after deductible
Private Duty Nursing - Outpatient	10%	20%; after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Outpatient Short-Term Rehabilitation	Covered 100%	20%; after deductible
Includes Speech, Physical, and Occupational Therapy.		
Autism	$10 office visit copay	20%; after deductible
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.		
Spinal Manipulation Therapy Limited to 30 visits per calendar year.	$10 office visit copay	20%; after deductible

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Hearing Aids	Covered 100%	20%; 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.		
Durable Medical Equipment	10%	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered 100%	20%; after deductible
Prosthetics	Covered 100%	20%; after deductible
Orthotics	Covered 100%	20%; after deductible
Fertility Drugs (oral and injectable)	10%	20%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	20%; after deductible
Generic FDA-approved Women's Contraceptives	Covered 100%	Not Covered
Transplants	Covered 100%. Preferred coverage is provided at an IOE contracted facility only	20%; after deductible
Bariatric Surgery	Covered 100%	20%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	$10 office visit copay. Inpatient hospital and outpatient facility, 100%.	20%; after deductible
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	$10 office visit copay. Inpatient hospital and outpatient facility, 100%.	20%; after deductible
Coverage includes Artificial Insemination and Ovulation Induction.		
Advanced Reproductive Technology (ART)	$10 office visit copay. Inpatient hospital and outpatient facility, 100%.	20%; after deductible
Member cost sharing does not apply towards the Out-of-Pocket Maximum. ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Covered at 4 completed egg retrievals per lifetime		
Vasectomy	$10 office visit copay. Inpatient hospital and outpatient facility, 100%.	20%; after deductible
Tubal Ligation	Covered 100%	20%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Retail (2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be doubled)	$10 copay for formulary generic drugs, $20 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies. $20 copay for formulary generic drugs, $40 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name and generic drugs up to a 31-60 day supply at participating pharmacies. $30 copay for formulary generic drugs, $60 copay for formulary brand-name drugs, and $120 copay for non-formulary brand-name and generic drugs up to a 61-90 day supply at participating pharmacies.	20% after deductible, for generic drugs, for formulary brand-name drugs, and for non-formulary brand-name drugs up to a 30 day supply at non-participating pharmacies.
Mail Order	$5 copay for generic drugs, $30 copay for formulary brand-name drugs, $50 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Applicable
Prescription Drug - Out-of-Pocket Maximum per calendar year:	$ 1,322 per person	
Aetna Specialty CareRx: please refer to retail copays.		
Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay only, if the physician requires brand.		
Plan Includes: Diabetic supplies.		
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited). Precert for growth hormones included. Expanded 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	

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For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.
If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

**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.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.

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.

Plans are provided by: Aetna Life 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.

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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 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 traduccion 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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