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HealthNetworkOnlyOpenAccess | NJ 01/01/2017

SP (Savings Plus) Plans are offered in Northern New Jersey (S1 service area) and Southern New Jersey (S2 service area).

Member benefits

Plan name	NJ Gold SP HNOnly 500 90/50 EMB		NJ Silver SP HNOnly 1500 70/50 EMB		NJ Silver SP HNOnly 2000 70/50 EMB	
	In Network	Non-Designated	In Network	Non-Designated	In Network	Non-Designated
Deductible (Individual/Family)	$500/$1,000	$2,000/$4,000	$1,500/$3,000	$1,500/$3,000	$2,000/$4,000	$2,000/$4,000
Out-of-pocket limit (Individual/Family)	$5,000/$10,000	$5,000/$10,000	$7,150/$14,300	$7,150/$14,300	$7,150/$14,300	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	Embedded [1]		Embedded [1]		Embedded [1]	
Primary care physician office visit	$35 copay; deductible waived	50% after deductible	$35 copay; deductible waived	50% after deductible	$35 copay; deductible waived	50% after deductible
Specialist office visit	$50 copay; deductible waived	50% after deductible	$50 copay; deductible waived	50% after deductible	$50 copay; deductible waived	50% after deductible
Walk-in clinics	$35 copay; deductible waived	Paid at the designated level	$35 copay; deductible waived	Paid at the designated level	$35 copay; deductible waived	Paid at the designated level
Diagnostic testing: Lab	Covered in full; deductible waived	Paid at the designated level	Covered in full after deductible	Paid at the designated level	Covered in full; deductible waived	Paid at the designated level
Diagnostic testing: X-ray	10% after deductible	Paid at the designated level	30% after deductible	Paid at the designated level	30% after deductible	Paid at the designated level
Imaging CT/PET scans MRIs	10% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Inpatient hospital facility	10% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient surgery	10% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Emergency room	$100 copay plus 10% after deductible	Paid at the designated level	$100 copay plus 30% after deductible	Paid at the designated level	$100 copay plus 30% after deductible	Paid at the designated level
Urgent care	$50 copay; deductible waived	Paid at the designated level	$50 copay; deductible waived	Paid at the designated level	$50 copay; deductible waived	Paid at the designated level
Rehabilitation services (PT/OT/ST) [3]	10% after deductible	Paid at the designated level	30% after deductible	Paid at the designated level	30% after deductible	Paid at the designated level
Chiropractic [4]	25% after deductible	Paid at the designated level	25% after deductible	Paid at the designated level	25% after deductible	Paid at the designated level
Pharmacy [5]	In Network		In Network		In Network	
Pharmacy Deductible	None		None		None	
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay		$20 copay		$20 copay	
Preferred Brand drugs including Specialty	50% up to $125		50% up to $125		50% up to $125	
Nonpreferred Brand drugs including Specialty	50% up to $150		50% up to $150		50% up to $150	

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ElectChoice | NJ 01/01/2017

Member benefits

Plan name	NJ Gold EPO 500D EMB	NJ Gold EPO 1500 70% 10/40/75 EMB	NJ Gold EPO 1500 70% 20/50/75 EMB	NJ Silver EPO 2000 50% EMB	NJ Silver EPO 2250 100% HSA TIF[6]
	In Network	In Network	In Network	In Network	In Network
Deductible (Individual/Family)	$0/$0	$1,500/$3,000	$1,500/$3,000	$2,000/$4,000	$2,250/$4,500
Out-of-pocket limit (Individual/Family)	$7,150/$14,300	$3,500/$7,000	$3,500/$7,000	$7,150/$14,300	$6,450/$6,450
Deductible and out-of-pocket limit accumulation	Embedded [1]	Embedded [1]	Embedded [1]	Embedded [1]	TIF [2]
Primary care physician office visit	$40 copay	$20 copay; deductible waived	$20 copay; deductible waived	$30 copay; deductible waived	Covered in full after deductible
Specialist office visit	$60 copay	$40 copay; deductible waived	$40 copay; deductible waived	$50 copay; deductible waived	Covered in full after deductible
Walk-in clinics	$40 copay	$20 copay; deductible waived	$20 copay; deductible waived	$30 copay; deductible waived	Covered in full after deductible
Diagnostic testing: Lab	$35 copay	$5 copay; deductible waived	$5 copay; deductible waived	$15 copay; deductible waived	$15 copay after deductible
Diagnostic testing: X-ray	$50 copay	$40 copay; deductible waived	$40 copay; deductible waived	$50 copay; deductible waived	$40 copay after deductible
Imaging CT/PET scans MRIs	40%	30% deductible waived	30% deductible waived	50% deductible waived	$100 copay after deductible
Inpatient hospital facility	$500/d, days 1-5	30% after deductible	30% after deductible	50% after deductible	Covered in full after deductible
Outpatient surgery	Freestanding facility: $250 copay /Hospital:	30% after deductible	30% after deductible	50% after deductible	Covered in full after deductible
Emergency room	$100 copay plus 30%	$100 copay plus 30% deductible waived	$100 copay plus 30% deductible waived	$100 copay plus 50% deductible waived	$100 copay plus 30% after deductible
Urgent care	$60 copay	$40 copay; deductible waived	$40 copay; deductible waived	$50 copay; deductible waived	Covered in full after deductible
Rehabilitation services (PT/OT/ST) [3]	$20 copay	$20 copay; deductible waived	$20 copay; deductible waived	$20 copay; deductible waived	$20 copay after deductible
Chiropractic [4]	25%	25% deductible waived	25% deductible waived	25% deductible waived	Covered in full after deductible
Pharmacy [5]	In Network	In Network	In Network	In Network	In Network
Pharmacy Deductible	None	None	None	None	Integrated with Medical Deductible
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay	$10 copay	$20 copay	$20 copay	$20 copay after deductible
Preferred Brand drugs including Specialty	$50 copay	$40 copay	$50 copay	$50 copay	$50 copay after deductible
Nonpreferred Brand drugs including Specialty	$75 copay	$75 copay	$75 copay	$75 copay	$75 copay after deductible

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ManagedChoice | NJ 01/01/2017

Member benefits

Plan name	NJ Silver MC 2000 70/50 EMB	
	In Network	Out of Network
Deductible (Individual/Family)	$2,000/$4,000	$5,000/$10,000
Out-of-pocket limit (Individual/Family)	$5,000/$10,000	$10,000/$20,000
Deductible and out-of-pocket limit accumulation	Embedded [1]	
Primary care physician office visit	30% after deductible	50% after deductible
Specialist office visit	30% after deductible	50% after deductible
Walk-in clinics	30% after deductible	50% after deductible
Diagnostic testing: Lab	30% after deductible	50% after deductible
Diagnostic testing: X-ray	30% after deductible	50% after deductible
Imaging CT/PET scans MRIs	30% after deductible	50% after deductible
Inpatient hospital facility	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	50% after deductible
Emergency room	$100 copay plus 30% after deductible	Paid as In-Network
Urgent care	30% after deductible	Paid as In-Network
Rehabilitation services (PT/OT/ST) [3]	30% after deductible	50% after deductible
Chiropractic [4]	25% after deductible	25% after deductible
Pharmacy [5]	In Network	Out of Network
Pharmacy Deductible	None	None
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay	50%
Preferred Brand drugs including Specialty	$50 copay	50%
Nonpreferred Brand drugs including Specialty	$75 copay	50%

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Indemnity | NJ 01/01/2017

Member benefits

Plan name	NJ Gold Indemnity 500 80% EMB	NJ Silver Indemnity 1200 70% EMB
	Out of Network	Out of Network
Deductible (Individual/Family)	$500/$1,000	$1,200/$2,400
Out-of-pocket limit (Individual/Family)	$6,000/$12,000	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	Embedded [1]	Embedded [1]
Primary care physician office visit	20% after deductible	30% after deductible
Specialist office visit	20% after deductible	30% after deductible
Walk-in clinics	20% after deductible	30% after deductible
Diagnostic testing: Lab	20% after deductible	30% after deductible
Diagnostic testing: X-ray	20% after deductible	30% after deductible
Imaging CT/PET scans MRIs	20% after deductible	30% after deductible
Inpatient hospital facility	20% after deductible	30% after deductible
Outpatient surgery	20% after deductible	30% after deductible
Emergency room	20% after deductible	30% after deductible
Urgent care	20% after deductible	30% after deductible
Rehabilitation services (PT/OT/ST) [3]	20% after deductible	30% after deductible
Chiropractic [4]	20% after deductible	25% after deductible

Pharmacy [5]	In Network	Out of Network	In Network	Out of Network
Pharmacy Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible
Preferred & Nonpreferred Generic drugs including Specialty	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Preferred Brand drugs including Specialty	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Nonpreferred Brand drugs including Specialty	20% after deductible	20% after deductible	30% after deductible	30% after deductible

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HMO | NJ 01/01/2017

SP (Savings Plus) Plans are offered in Northern New Jersey (S1 service area) and Southern New Jersey (S2 service area).

Member benefits

Plan name	NJ Silver HMO 2000 70% EMB	NJ Silver Savings Plus HMO 2000 70/50 EMB	
	In Network	In Network	Non-Designated
Deductible (Individual/Family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
Out-of-pocket limit (Individual/Family)	$5,000/$10,000	$7,150/$14,300	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	Embedded [1]	Embedded [1]	
Primary care physician office visit	30% after deductible	$35 copay; deductible waived	50% after deductible
Specialist office visit	30% after deductible	$50 copay; deductible waived	50% after deductible
Walk-in clinics	30% after deductible	$35 copay; deductible waived	Paid at the designated level
Diagnostic testing: Lab	30% after deductible	Covered in full; deductible waived	Paid at the designated level
Diagnostic testing: X-ray	30% after deductible	30% after deductible	Paid at the designated level
Imaging CT/PET scans MRIs	30% after deductible	30% after deductible	50% after deductible
Inpatient hospital facility	30% after deductible	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	30% after deductible	50% after deductible
Emergency room	$100 copay plus 30% after deductible	$100 copay plus 30% after deductible	Paid at the designated level
Urgent care	30% after deductible	$50 copay; deductible waived	Paid at the designated level
Rehabilitation services (PT/OT/ST) [3]	30% after deductible	30% after deductible	Paid at the designated level
Chiropractic [4]	25% after deductible	25% after deductible	Paid at the designated level
Pharmacy [5]	In Network	In Network	
Pharmacy Deductible	None	None	
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay	$20 copay	
Preferred Brand drugs including Specialty	$50 copay	50% up to $125	
Nonpreferred Brand drugs including Specialty	$75 copay	50% up to $150	

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Member benefits

Plan name	NJ Gold OAEPO 500D EMB	NJ Gold OAEPO 70% EMB	NJ Gold OAEPO 1500 70% 10/40/75 EMB	NJ Gold OAEPO 1500 70% 20/50/75 EMB	NJ Silver OAEPO 2000 20/50/75 HSA TIF[6]
	In Network	In Network	In Network	In Network	In Network
Deductible (Individual/Family)	$0/$0	$0/$0	$1,500/$3,000	$1,500/$3,000	$2,000/$4,000
Out-of-pocket limit (Individual/Family)	$7,150/$14,300	$6,000/$12,000	$3,500/$7,000	$3,500/$7,000	$6,000/$6,000
Deductible and out-of-pocket limit accumulation	Embedded [1]	Embedded [1]	Embedded [1]	Embedded [1]	TIF [2]
Primary care physician office visit	$40 copay	$30 copay	$20 copay; deductible waived	$20 copay; deductible waived	$20 copay after deductible
Specialist office visit	$60 copay	$50 copay	$40 copay; deductible waived	$40 copay; deductible waived	$40 copay after deductible
Walk-in clinics	$40 copay	$30 copay	$20 copay; deductible waived	$20 copay; deductible waived	$20 copay after deductible
Diagnostic testing: Lab	$35 copay	$10 copay	$5 copay; deductible waived	$5 copay; deductible waived	$15 copay after deductible
Diagnostic testing: X-ray	$50 copay	$40 copay	$40 copay; deductible waived	$40 copay; deductible waived	$40 copay after deductible
Imaging CT/PET scans MRIs	40%	30%	30% deductible waived	30% deductible waived	40% after deductible
Inpatient hospital facility	$500/d, days 1-5	30%	30% after deductible	30% after deductible	$400/d, days 1-5 after deductible
Outpatient surgery	Freestanding facility: $250 copay /Hospital: $500 copay	30%	30% after deductible	30% after deductible	$200 copay after deductible
Emergency room	$100 copay plus 30%	$100 copay plus 30%	$100 copay plus 30% deductible waived	$100 copay plus 30% deductible waived	$100 copay after deductible
Urgent care	$60 copay	$50 copay	$40 copay; deductible waived	$40 copay; deductible waived	$40 copay after deductible
Rehabilitation services (PT/OT/ST) [3]	$20 copay	$10 copay	$20 copay; deductible waived	$20 copay; deductible waived	$15 copay after deductible
Chiropractic [4]	25%	25%	25% deductible waived	25% deductible waived	25% after deductible
Pharmacy [5]	In Network	In Network	In Network	In Network	In Network
Pharmacy Deductible	None	None	None	None	Integrated with Medical Deductible
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay	$20 copay	$10 copay	$20 copay	$20 copay after deductible
Preferred Brand drugs including Specialty	$50 copay	$50 copay	$40 copay	$50 copay	$50 copay after deductible
Nonpreferred Brand drugs including Specialty	$75 copay	$75 copay	$75 copay	$75 copay	$75 copay after deductible

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Member benefits

Plan name	NJ Silver OAEPO 2000 90% HSA TIF[6]	NJ Silver OAEPO 2000 70% EMB	NJ Silver OAEPO 2000 50% EMB	NJ Bronze OAEPO 2500 50% HSA TIF[6]	NJ Bronze OAEPO 3000 50% HSA TIF[6]
	In Network	In Network	In Network	In Network	In Network
Deductible (Individual/Family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000
Out-of-pocket limit (Individual/Family)	$6,450/$6,450	$5,000/$10,000	$7,150/$14,300	$6,450/$6,450	$6,450/$6,450
Deductible and out-of-pocket limit accumulation	TIF [2]	Embedded [1]	Embedded [1]	TIF [2]	TIF [2]
Primary care physician office visit	10% after deductible	30% after deductible	$30 copay; deductible waived	50% after deductible	50% after deductible
Specialist office visit	10% after deductible	30% after deductible	$50 copay; deductible waived	50% after deductible	50% after deductible
Walk-in clinics	10% after deductible	30% after deductible	$30 copay; deductible waived	50% after deductible	50% after deductible
Diagnostic testing: Lab	10% after deductible	30% after deductible	$15 copay; deductible waived	$30 copay after deductible	$30 copay after deductible
Diagnostic testing: X-ray	10% after deductible	30% after deductible	$50 copay; deductible waived	50% after deductible	50% after deductible
Imaging CT/PET scans MRIs	10% after deductible	30% after deductible	50% deductible waived	50% after deductible	50% after deductible
Inpatient hospital facility	10% after deductible	30% after deductible	50% after deductible	$300/d, days 1-5 after deductible	$300/d, days 1-5 after deductible
Outpatient surgery	10% after deductible	30% after deductible	50% after deductible	50% after deductible	50% after deductible
Emergency room	$100 copay plus 10% after deductible	$100 copay plus 30% after deductible	$100 copay plus 50% deductible waived	$100 copay plus 50% after deductible	$100 copay plus 50% after deductible
Urgent care	10% after deductible	30% after deductible	$50 copay; deductible waived	50% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST) [3]	10% after deductible	30% after deductible	$20 copay; deductible waived	$30 copay after deductible	$30 copay after deductible
Chiropractic [4]	10% after deductible	25% after deductible	25% deductible waived	25% after deductible	25% after deductible
Pharmacy [5]	In Network	In Network	In Network	In Network	In Network
Pharmacy Deductible	Integrated with Medical Deductible	None	None	Integrated with Medical Deductible	Integrated with Medical Deductible
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay after deductible	$20 copay	$20 copay	50% after deductible	50% after deductible
Preferred Brand drugs including Specialty	$50 copay after deductible	$50 copay	$50 copay	50% after deductible	50% after deductible
Nonpreferred Brand drugs including Specialty	$75 copay after deductible	$75 copay	$75 copay	50% after deductible	50% after deductible

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ElectChoiceOpenAccess
HMH=Hackensack Meridian Health

Member benefits

Plan name	NJ Gold AWH HMH OAEPO 30/50 500D E		NJ Gold AWH HMH OAEPO 25/50 500D E	
	Designated	Non-Designated	Designated	Non-Designated
Deductible (Individual/Family)	$0/$0	$2,500/$5,000	$0/$0	$2,500/$5,000
Out-of-pocket limit (Individual/Family)	$6,600/$13,200	$6,600/$13,200	$4,000/$8,000	$6,250/$12,500
Deductible and out-of-pocket limit accumulation	Embedded [1]		Embedded [1]	
Primary care physician office visit	$30 copay	50% after deductible	$25 copay	$40 copay after deductible
Specialist office visit	$50 copay	50% after deductible	$50 copay	$60 copay after deductible
Walk-in clinics	$30 copay	Paid at the designated level	$25 copay	Paid at the designated level
Diagnostic testing: Lab	$15 copay	50% after deductible	$15 copay	30% after deductible
Diagnostic testing: X-ray	$50 copay	50% after deductible	$50 copay	30% after deductible
Imaging CT/PET scans MRIs	40%	50% after deductible	30%	30% after deductible
Inpatient hospital facility	$500/d, days 1-5	50% after deductible	$500/d, days 1-5	30% after deductible
Outpatient surgery	Freestanding facility: $500 copay /Hospital: $500 copay	Freestanding facility: 50% after deductible /Hospital: 50% after deductible	Freestanding facility: $500 copay /Hospital: $500 copay	Freestanding facility: 30% after deductible /Hospital: 30% after deductible
Emergency room	$100 copay	Paid at the designated level	$100 copay	Paid at the designated level
Urgent care	$50 copay	Paid at the designated level	$50 copay	Paid at the designated level
Rehabilitation services (PT/OT/ST) [3]	$20 copay	50% after deductible	$50 copay	30% after deductible
Chiropractic [4]	25%	Paid at the designated level	25%	Paid at the designated level
Pharmacy [5]	In Network		In Network	
Pharmacy Deductible	None		None	
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay		$20 copay	
Preferred Brand drugs including Specialty	50% up to $125		50% up to $125	
Nonpreferred Brand drugs including Specialty	50% up to $150		50% up to $150	

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ElectChoiceOpenAccess
HMH=Hackensack Meridian Health

Member benefits

Plan name	NJ Silver AWH HMH OAEPO 1750 90/70 HSA T[6]		NJ Bronze AWH HMH OAEPO 3000 100/50 E	
	Designated	Non-Designated	Designated	Non-Designated
Deductible (Individual/Family)	$1,750/$3,500	$2,650/$5,300	$3,000/$6,000	$3,000/$6,000
Out-of-pocket limit (Individual/Family)	$6,550/$6,550	$6,550/$6,550	$7,150/$14,300	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	TIF [2]		Embedded [1]	
Primary care physician office visit	$10 copay after deductible	$25 copay after deductible	$30 copay after deductible	50% after deductible
Specialist office visit	$25 copay after deductible	$40 copay after deductible	$60 copay after deductible	50% after deductible
Walk-in clinics	$10 copay after deductible	Paid at the designated level	$30 copay after deductible	Paid at the designated level
Diagnostic testing: Lab	10% after deductible	30% after deductible	$35 copay after deductible	50% after deductible
Diagnostic testing: X-ray	10% after deductible	30% after deductible	50% after deductible	50% after deductible
Imaging CT/PET scans MRIs	10% after deductible	30% after deductible	50% after deductible	50% after deductible
Inpatient hospital facility	10% after deductible	30% after deductible	$500/d, days 1-5 after deductible	50% after deductible
Outpatient surgery	Freestanding facility: 10% after deductible /Hospital: 10% after deductible	Freestanding facility: 30% after deductible /Hospital: 30% after deductible	Freestanding facility: 50% after deductible /Hospital: 50% after deductible	Freestanding facility: 50% after deductible /Hospital: 50% after deductible
Emergency room	$100 copay plus 10% after deductible	Paid at the designated level	$100 copay plus 50% after deductible	Paid at the designated level
Urgent care	$25 copay after deductible	Paid at the designated level	$60 copay after deductible	Paid at the designated level
Rehabilitation services (PT/OT/ST) [3]	10% after deductible	30% after deductible	$50 copay after deductible	50% after deductible
Chiropractic [4]	25% after deductible	Paid at the designated level	25% after deductible	Paid at the designated level
Pharmacy [5]	In Network		In Network	
Pharmacy Deductible	Integrated with Medical Deductible		None	
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay after deductible		$20 copay	
Preferred Brand drugs including Specialty	50% up to $125 after deductible		50% up to $125	
Nonpreferred Brand drugs including Specialty	50% up to $150 after deductible		50% up to $150	

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Member benefits

Plan name	NJ Gold AWH Virtua OAEPO 30/50 500D E		NJ Gold AWH Virtua OAEPO 25/50 500D E	
	Designated	Non-Designated	Designated	Non-Designated
Deductible (Individual/Family)	$0/$0	$2,500/$5,000	$0/$0	$2,500/$5,000
Out-of-pocket limit (Individual/Family)	$6,600/$13,200	$6,600/$13,200	$4,000/$8,000	$6,250/$12,500
Deductible and out-of-pocket limit accumulation	Embedded [1]		Embedded [1]	
Primary care physician office visit	$30 copay	50% after deductible	$25 copay	$40 copay after deductible
Specialist office visit	$50 copay	50% after deductible	$50 copay	$60 copay after deductible
Walk-in clinics	$30 copay	Paid at the designated level	$25 copay	Paid at the designated level
Diagnostic testing: Lab	$15 copay	50% after deductible	$15 copay	30% after deductible
Diagnostic testing: X-ray	$50 copay	50% after deductible	$50 copay	30% after deductible
Imaging CT/PET scans MRIs	40%	50% after deductible	30%	30% after deductible
Inpatient hospital facility	$500/d, days 1-5	50% after deductible	$500/d, days 1-5	30% after deductible
Outpatient surgery	Freestanding facility: $500 copay /Hospital: $500 copay	Freestanding facility: 50% after deductible /Hospital:	Freestanding facility: $500 copay /Hospital: $500 copay	Freestanding facility: 30% after deductible /Hospital:
Emergency room	$100 copay	Paid at the designated level	$100 copay	Paid at the designated level
Urgent care	$50 copay	Paid at the designated level	$50 copay	Paid at the designated level
Rehabilitation services (PT/OT/ST) [3]	$20 copay	50% after deductible	$50 copay	30% after deductible
Chiropractic [4]	25%	Paid at the designated level	25%	Paid at the designated level
Pharmacy [5]	In Network		In Network	
Pharmacy Deductible	None		None	
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay		$20 copay	
Preferred Brand drugs including Specialty	50% up to $125		50% up to $125	
Nonpreferred Brand drugs including Specialty	50% up to $150		50% up to $150	

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Aetna 1-50 ElectChoiceOpenAccess NJ 01/01/2017

Member benefits

Plan name	NJ Silver AWH Virtua OAEPO 1750 90/70 HSA T6		NJ Bronze AWH Virtua OAEPO 3000 100/50 E	
	Designated	Non-Designated	Designated	Non-Designated
Deductible (Individual/Family)	$1,750/$3,500	$2,650/$5,300	$3,000/$6,000	$3,000/$6,000
Out-of-pocket limit (Individual/Family)	$6,550/$6,550	$6,550/$6,550	$7,150/$14,300	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	TIF [2]		Embedded [1]	
Primary care physician office visit	$10 copay after deductible	$25 copay after deductible	$30 copay after deductible	50% after deductible
Specialist office visit	$25 copay after deductible	$40 copay after deductible	$60 copay after deductible	50% after deductible
Walk-in clinics	$10 copay after deductible	Paid at the designated level	$30 copay after deductible	Paid at the designated level
Diagnostic testing: Lab	10% after deductible	30% after deductible	$35 copay after deductible	50% after deductible
Diagnostic testing: X-ray	10% after deductible	30% after deductible	50% after deductible	50% after deductible
Imaging CT/PET scans MRIs	10% after deductible	30% after deductible	50% after deductible	50% after deductible
Inpatient hospital facility	10% after deductible	30% after deductible	$500/d, days 1-5 after deductible	50% after deductible
Outpatient surgery	Freestanding facility: 10% after deductible /Hospital:	Freestanding facility: 30% after deductible /Hospital:	Freestanding facility: 50% after deductible /Hospital:	Freestanding facility: 50% after deductible /Hospital:
Emergency room	$100 copay plus 10% after deductible	Paid at the designated level	$100 copay plus 50% after deductible	Paid at the designated level
Urgent care	$25 copay after deductible	Paid at the designated level	$60 copay after deductible	Paid at the designated level
Rehabilitation services (PT/OT/ST) [3]	10% after deductible	30% after deductible	$50 copay after deductible	50% after deductible
Chiropractic [4]	25% after deductible	Paid at the designated level	25% after deductible	Paid at the designated level
Pharmacy [5]	In Network		In Network	
Pharmacy Deductible	Integrated with Medical Deductible		None	
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay after deductible		$20 copay	
Preferred Brand drugs including Specialty	50% up to $125 after deductible		50% up to $125	
Nonpreferred Brand drugs including Specialty	50% up to $150 after deductible		50% up to $150	

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Member benefits

Plan name	NJ Gold OAMC 100/60 300D EMB		NJ Gold OAMC 70/50 EMB		NJ Silver OAMC 1500 70/50 EMB	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible (Individual/Family)	$0/$0	$3,000/$6,000	$0/$0	$5,000/$10,000	$1,500/$3,000	$4,500/$9,000
Out-of-pocket limit (Individual/Family)	$7,150/$14,300	$10,000/$20,000	$6,000/$12,000	$10,000/$20,000	$7,150/$14,300	$10,000/$20,000
Deductible and out-of-pocket limit accumulation	Embedded [1]		Embedded [1]		Embedded [1]	
Primary care physician office visit	$20 copay	40% after deductible	$30 copay	50% after deductible	$35 copay; deductible waived	50% after deductible
Specialist office visit	$60 copay	40% after deductible	$50 copay	50% after deductible	$60 copay; deductible waived	50% after deductible
Walk-in clinics	$20 copay	40% after deductible	$30 copay	50% after deductible	$35 copay; deductible waived	50% after deductible
Diagnostic testing: Lab	$50 copay	40% after deductible	$10 copay	50% after deductible	$15 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	$50 copay	40% after deductible	$40 copay	50% after deductible	$50 copay; deductible waived	50% after deductible
Imaging CT/PET scans MRIs	30%	40% after deductible	30%	50% after deductible	50% deductible waived	50% after deductible
Inpatient hospital facility	$300/d, days 1-5	40% after deductible	30%	50% after deductible	30% after deductible	50% after deductible
Outpatient surgery	Freestanding facility: $300 copay /Hospital: $300 copay	Freestanding facility: 40% after deductible /Hospital: 40% after deductible	Freestanding facility: 30% /Hospital: 30%	Freestanding facility: 50% after deductible /Hospital: 50% after deductible	Freestanding facility: 30% after deductible /Hospital: 30% after deductible	Freestanding facility: 50% after deductible /Hospital: 50% after deductible
Emergency room	$100 copay plus 30%	Paid as In-Network	$100 copay plus 30%	Paid as In-Network	$100 copay plus 50% deductible waived	Paid as In-Network
Urgent care	$60 copay	Paid as In-Network	$50 copay	Paid as In-Network	$60 copay; deductible waived	Paid as In-Network
Rehabilitation services (PT/OT/ST) [3]	$50 copay	40% after deductible	$10 copay	50% after deductible	$50 copay; deductible waived	50% after deductible
Chiropractic [4]	25%	25% after deductible	25%	25% after deductible	25% deductible waived	25% after deductible
Pharmacy [5]	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Pharmacy Deductible	None	None	None	None	None	None
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay	50%	$20 copay	50%	$20 copay	50%
Preferred Brand drugs including Specialty	$50 copay	50%	$50 copay	50%	$50 copay	50%
Nonpreferred Brand drugs including Specialty	$75 copay	50%	$75 copay	50%	$75 copay	50%

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Member benefits

Plan name	NJ Silver OAMC 2000 20/50/75 HSA TIF[6]		NJ Silver OAMC 2000 60/50 EMB		NJ Bronze OAMC 2500 50/50 HSA TIF[6]	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible (Individual/Family)	$2,000/$4,000	$4,000/$8,000	$2,000/$4,000	$5,000/$10,000	$2,500/$5,000	$5,000/$10,000
Out-of-pocket limit (Individual/Family)	$6,000/$6,000	$8,000/$16,000	$7,150/$14,300	$10,000/$20,000	$6,450/$6,450	$10,000/$20,000
Deductible and out-of-pocket limit accumulation	TIF [2]		Embedded [1]		TIF [2]	
Primary care physician office visit	$20 copay after deductible	50% after deductible	$30 copay; deductible waived	50% after deductible	50% after deductible	50% after deductible
Specialist office visit	$40 copay after deductible	50% after deductible	$50 copay; deductible waived	50% after deductible	50% after deductible	50% after deductible
Walk-in clinics	$20 copay after deductible	50% after deductible	$30 copay; deductible waived	50% after deductible	50% after deductible	50% after deductible
Diagnostic testing: Lab	$15 copay after deductible	50% after deductible	$15 copay; deductible waived	50% after deductible	$30 copay after deductible	50% after deductible
Diagnostic testing: X-ray	$40 copay after deductible	50% after deductible	$50 copay; deductible waived	50% after deductible	50% after deductible	50% after deductible
Imaging CT/PET scans MRIs	40% after deductible	50% after deductible	50% deductible waived	50% after deductible	50% after deductible	50% after deductible
Inpatient hospital facility	$400/d, days 1-5 after deductible	50% after deductible	40% after deductible	50% after deductible	$300/d, days 1-5 after deductible	50% after deductible
Outpatient surgery	Freestanding facility: $200 copay after deductible /Hospital: $200 copay after deductible	Freestanding facility: 50% after deductible /Hospital: 50% after deductible	Freestanding facility: 40% after deductible /Hospital: 40% after deductible	Freestanding facility: 50% after deductible /Hospital: 50% after deductible	Freestanding facility: 50% after deductible /Hospital: 50% after deductible	Freestanding facility: 50% after deductible /Hospital: 50% after deductible
Emergency room	$100 copay after deductible	Paid as In-Network	$100 copay plus 50% deductible waived	Paid as In-Network	$100 copay plus 50% after deductible	Paid as In-Network
Urgent care	$40 copay after deductible	Paid as In-Network	$50 copay; deductible waived	Paid as In-Network	50% after deductible	Paid as In-Network
Rehabilitation services (PT/OT/ST) [3]	$15 copay after deductible	50% after deductible	$20 copay; deductible waived	50% after deductible	$30 copay after deductible	50% after deductible
Chiropractic [4]	25% after deductible	25% after deductible	25% deductible waived	25% after deductible	25% after deductible	25% after deductible
Pharmacy [5]	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Pharmacy Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible	None	None	Integrated with Medical Deductible	Integrated with Medical Deductible
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay after deductible	50% after deductible	$20 copay	50%	50% after deductible	50% after deductible
Preferred Brand drugs including Specialty	$50 copay after deductible	50% after deductible	$50 copay	50%	50% after deductible	50% after deductible
Nonpreferred Brand drugs including Specialty	$75 copay after deductible	50% after deductible	$75 copay	50%	50% after deductible	50% after deductible

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Member benefits

Plan name	NJ Bronze OAMC 3000 50/50 HSA TIF6	
	In Network	Out of Network
Deductible (Individual/Family)	$3,000/$6,000	$5,000/$10,000
Out-of-pocket limit (Individual/Family)	$6,450/$6,450	$10,000/$20,000
Deductible and out-of-pocket limit accumulation	TIF [2]	
Primary care physician office visit	50% after deductible	50% after deductible
Specialist office visit	50% after deductible	50% after deductible
Walk-in clinics	50% after deductible	50% after deductible
Diagnostic testing: Lab	$30 copay after deductible	50% after deductible
Diagnostic testing: X-ray	50% after deductible	50% after deductible
Imaging CT/PET scans MRIs	50% after deductible	50% after deductible
Inpatient hospital facility	$300/d, days 1-5 after deductible	50% after deductible
Outpatient surgery	Freestanding facility: 50% after deductible /Hospital: 50% after deductible	Freestanding facility: 50% after deductible /Hospital: 50% after deductible
Emergency room	$100 copay plus 50% after deductible	Paid as In-Network
Urgent care	50% after deductible	Paid as In-Network
Rehabilitation services (PT/OT/ST) [3]	$30 copay after deductible	50% after deductible
Chiropractic [4]	25% after deductible	25% after deductible
Pharmacy [5]	In Network	Out of Network
Pharmacy Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible
Preferred & Nonpreferred Generic drugs including Specialty	50% after deductible	50% after deductible
Preferred Brand drugs including Specialty	50% after deductible	50% after deductible
Nonpreferred Brand drugs including Specialty	50% after deductible	50% after deductible

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Member benefits

Plan name	NJ Silver QPOS 2000 70/50 EMB	
	In Network	Out of Network
Deductible (Individual/Family)	$2,000/$4,000	$5,000/$10,000
Out-of-pocket limit (Individual/Family)	$5,000/$10,000	$10,000/$20,000
Deductible and out-of-pocket limit accumulation	Embedded [1]	
Primary care physician office visit	30% after deductible	50% after deductible
Specialist office visit	30% after deductible	50% after deductible
Walk-in clinics	30% after deductible	50% after deductible
Diagnostic testing: Lab	30% after deductible	50% after deductible
Diagnostic testing: X-ray	30% after deductible	50% after deductible
Imaging CT/PET scans MRIs	30% after deductible	50% after deductible
Inpatient hospital facility	30% after deductible	50% after deductible
Outpatient surgery	Freestanding facility: 30% after deductible /Hospital: 30% after deductible	Freestanding facility: 50% after deductible /Hospital: 50% after deductible
Emergency room	$100 copay plus 30% after deductible	Paid as In-Network
Urgent care	30% after deductible	Paid as In-Network
Rehabilitation services (PT/OT/ST) [3]	30% after deductible	50% after deductible
Chiropractic [4]	25% after deductible	25% after deductible
Pharmacy [5]	In Network	Out of Network
Pharmacy Deductible	None	None
Preferred & Nonpreferred Generic drugs including Specialty	$20 copay	50%
Preferred Brand drugs including Specialty	$50 copay	50%
Nonpreferred Brand drugs including Specialty	$75 copay	50%

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Aetna Pediatric Dental & Vision

NJ 01/01/2017

Pediatric Dental Plans	Standard EPO/OA EPO plans with no deductible	HMO/EPO/ OA EPO plans with deductible	EPO/OA EPO HSA-compatible plans	Standard SP HNOnly plans/Standard SP HMO plans	
	In Network	In Network	In Network	In Network	Non-Designated
Preventive	0%	0%; deductible waived	0%; deductible waived	0%; deductible waived	0%; deductible waived
Dental Check-Up (aka diagnostic)	0%	0%; deductible waived	0%; after deductible	0%; deductible waived	Paid at the designated level
Dental Basic	30%	30% after deductible	30% after deductible	30% after deductible	Paid at the designated level
Dental Major	50%	50% after deductible	50% after deductible	50% after deductible	Paid at the designated level
Dental Ortho	50%	50% after deductible	50% after deductible	50% after deductible	Paid at the designated level

Pediatric vision plans	Standard EPO/OA EPO plans with no deductible	HMO/EPO/ OA EPO plans with deductible	EPO/OA EPO HSA-compatible plans	Standard SP HNOnly plans/Standard SP HMO plans	
	In Network	In Network	In Network	In Network	Non-Designated
Vision Exam (1 exam per 12 months)	0%	0%; deductible waived	0%; deductible waived	0%; deductible waived	0%; deductible waived
Pediatric Vision Hardware	0%	0%; deductible waived	0% after deductible	0%; deductible waived	Paid at the designated level

Notes

These plans do not cover all dental and vision expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.

*This vision plan will cover the following:

-One set of eyeglass frames per 12 months.

-One pair of prescription lenses per 12 months.

-Prescription contact lenses maximum per 12 months: daily disposables (up to three-month supply), extended wear disposable (up to six-month supply and nondisposable lenses (one set).

-Important Notes: This plan will cover either one pair of prescription lenses for eyeglass frames or prescription contact lenses, but not both, per 12 months.

Coverage does not include the office visit for the fitting of prescription contact lenses.

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Pediatric Dental Plans	Standard OAMC plans with no in-network deductible		Standard QPOS/MC/OAMC plans with in-network deductible	
	In Network	Out of Network	In Network	Out of Network
Preventive	0%	Not Covered	0%; deductible waived	Not Covered
Dental Check-Up (aka diagnostic)	0%	Not Covered	0%; after deductible	Not Covered
Dental Basic	30%	Not Covered	30% after deductible	Not Covered
Dental Major	50%	Not Covered	50% after deductible	Not Covered
Dental Ortho	50%	Not Covered	50% after deductible	Not Covered

Pediatric vision plans	Standard OAMC plans with no in-network deductible		Standard QPOS/MC/OAMC plans with in-network deductible	
	In Network	Out of Network	In Network	Out of Network
Vision Exam (1 exam per 12 months)	0%	Coinsurance after deductible	0%; deductible waived	50% after deductible
Pediatric Vision Hardware	0%	Not Covered	0%; deductible waived	Not Covered

Notes

These plans do not cover all dental and vision expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.

*This vision plan will cover the following:

-One set of eyeglass frames per 12 months.

-One pair of prescription lenses per 12 months.

-Prescription contact lenses maximum per 12 months: daily disposables (up to three-month supply), extended wear disposable (up to six-month supply and nondisposable lenses (one set).

-Important Notes: This plan will cover either one pair of prescription lenses for eyeglass frames or prescription contact lenses, but not both, per 12 months.

Coverage does not include the office visit for the fitting of prescription contact lenses.

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Pediatric Dental Plans	OAMC HSA-Compatible plans	Standard Indemnity plans
	Out of Network	Out of Network
Preventive	Not Covered	0%; deductible waived
Dental Check-Up (aka diagnostic)	Not Covered	0%; deductible waived
Dental Basic	Not Covered	30% after deductible
Dental Major	Not Covered	50% after deductible
Dental Ortho	Not Covered	50% after deductible

Pediatric vision plans	OAMC HSA-Compatible plans	Standard Indemnity plans
	Out of Network	Out of Network
Vision Exam (1 exam per 12 months)	50% after deductible	0%; deductible waived
Pediatric Vision Hardware	Not Covered	0%; deductible waived

Notes

These plans do not cover all dental and vision expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.

*This vision plan will cover the following:

-One set of eyeglass frames per 12 months.

-One pair of prescription lenses per 12 months.

-Prescription contact lenses maximum per 12 months: daily disposables (up to three-month supply), extended wear disposable (up to six-month supply and nondisposable lenses (one set).

-Important Notes: This plan will cover either one pair of prescription lenses for eyeglass frames or prescription contact lenses, but not both, per 12 months.

Coverage does not include the office visit for the fitting of prescription contact lenses.

Limitations and Exceptions

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. The following is a partial 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 purchased.

- All medical or hospital services not specifically covered in or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Adult dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Immunizations for travel or work
- Infertility services, including, but not limited to, 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
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

Limitations and Exceptions

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

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions.

Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law.

For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at www.aetna.com, or the Aetna Medication Formulary Guide.

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.

In addition, in circumstances where your prescription plan uses copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member.

Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services.

Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

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Footnotes

All services are subject to the deductible unless noted otherwise. Some benefits are subject to age and frequency schedules, limitations or visit maximums. Members or Providers may be required to precertify or obtain approval for certain services.

Note: Please refer to Aetna's Producer World® web site at **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Deductibles, copays and coinsurance apply to the out-of-pocket maximum (OOP). After the out of pocket maximum is met, members continue to be responsible for any applicable premiums, penalties for failure to precertify (where applicable) and services not covered by Aetna.

[1] **Embedded** – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the year (plan or calendar based on plan design).

[2] **TIF (Non-Embedded) -** The individual deductible/out-of-pocket limit can only be met when a member is enrolled for self only coverage with no dependent coverage. The family deductible/out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the year (plan or calendar based on plan design).

[3] **Rehabilitation services** - Coverage is limited to 30 visits per year (plan or calendar based on plan design) combined for physical and occupational therapy. Coverage is limited to 30 visits per year (plan or calendar based on plan design) for speech therapy/cognitive therapy. Benefit limits are separate between rehabilitation and habilitation services for physical/occupational/speech therapy.

[4] **Chiropractic/subluxation** services have a combined limit of 30 visits per year (plan or calendar based on plan design).

[5] **Pharmacy**

Choose Generic with DAW override applies - Member pays the difference in cost between a brand and generic drug plus the applicable cost share if a generic drug is available and a brand-name drug is dispensed unless the physician indicates "Dispense as Written" on the prescription. The cost difference between the generic and brand does not count toward the Out of Pocket Limit. Not all drugs are covered. It is important to look at the Drug List (Aetna Value Plus Formulary) to understand which drugs are covered.

[6] **Benefit year** - HSA plans are available on a calendar-year or plan-year basis.

Footnotes

Network

How your out-of-network care is reimbursed: 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.

Professional Services: 110% of Medicare / Facility Services: 140% of Medicare

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 your plan 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 (usually, for emergency services), some of our plans pay the bill as if you got care in network. For those plans, you pay cost sharing and deductibles based on your in-network level of benefits. You do not have to pay anything else. Other plans pay the bill differently. And, under those plans, you may be responsible for more than your in-network cost sharing. The additional amounts could be very large. Look at your plan or contact us to find out more about how your plan pays for emergency services.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/dental benefits and health/dental insurance and plans contain exclusions and limitations. Plan features and availability may vary by location and group size. Investment services are independently offered through PayFlex. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health and dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. 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. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

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