The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call **1-609-292-7524** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** person/**$1,000** family for out of network services only.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	In-network coinsurance limit **$800** person/ **$2,000** family; Active employee medical out of pocket limit **$6,320** person/**$12,640** family. Retiree medical out-of-pocket limit **$6,549** person/**$13,098** family. Out-of-network providers **$2,000** person/**$5,000** family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. Out of network reimbursement rate is 175% of CMS.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-877-STATENJ for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	30% coinsurance after deductible	———— none ————
	Specialist visit	$15 copay/visit	30% coinsurance after deductible	Chiropractic care is limited to 30 visits combined per calendar year. Out-of-network coverage for chiropractic and acupuncture services are limited to no more than $35 a visit for chiropractic and $60 a visit for acupuncture or 75% of the in network cost per visit, whichever is less. Out of network reimbursement rate is 175% of CMS.
	Preventive care/screening/ immunization	No Charge	Not Covered	One routine physical per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance after deductible	———— none ————
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance after deductible	Requires pre-approval
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	See separate Prescription Drug Plan SBC	See separate Prescription Drug Plan SBC	———— none ————
	Preferred brand drugs	See separate Prescription Drug Plan SBC	See separate Prescription Drug Plan SBC	———— none ————
	Non-preferred brand drugs	See separate Prescription Drug Plan SBC	See separate Prescription Drug Plan SBC	———— none ————
	Specialty drugs	See separate Prescription Drug Plan SBC	See separate Prescription Drug Plan SBC	———— none ————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance after deductible	———— none ————
	Physician/surgeon fees	No Charge	30% coinsurance after deductible	———— none ————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copay/visit $50 copay/visit for dependent children under 19 and members who obtain referral	$150 copay/visit $50 copay/visit for dependent children under 19 and members who obtain referral	Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.
	Emergency medical transportation	10% coinsurance	30% coinsurance after deductible	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
	Urgent care	$15 copay/visit	30% coinsurance after deductible	———————— none ————————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% coinsurance after deductible	Requires pre-approval. There is a separate $500 deductible per inpatient stay for out-of-network facilities.
	Physician/surgeon fees	No Charge	30% coinsurance after deductible	Requires pre-approval.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	30% coinsurance after deductible	Some specialty outpatient services require pre-approval. Inpatient services require pre-approval. There is a separate $500 deductible per inpatient stay for out-of-network facilities. Mental Health 195% CMS after reaching OON out of pocket maximum through 12/31/2020.
	Inpatient services	No Charge	30% coinsurance after deductible	
If you are pregnant	Office visits	$15 copay/visit	30% coinsurance after deductible	Copayment applies to initial visit only.
	Childbirth/delivery professional services	No Charge	30% coinsurance after deductible	Requires pre-approval. There is a separate $500 deductible per inpatient stay for out-of-network facilities. Members receiving obstetric services OON as of July 1, 2019 will be reimbursed at 195% of CMS for the duration of care.
	Childbirth/delivery facility services	No Charge	30% coinsurance after deductible	

If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance after deductible	Requires pre-approval.
	Rehabilitation services	$15 copay/visit	30% coinsurance after deductible	Requires pre-approval. Out- of network physical therapy will be limited to the rate that is equal to the average of the in network provider reimbursement.
	Habilitation services	$15 copay/visit	30% coinsurance after deductible	Requires pre-approval.
	Skilled nursing care	No Charge	30% coinsurance after deductible	Requires pre-approval. Limited to 120 days in-network and 60 out-of-network facility days for a combined maximum of 120 days per calendar year. There is a separate $500 deductible per inpatient stay for out-of-network facilities.
	Durable medical equipment	10% coinsurance	30% coinsurance after deductible	Requires pre-approval for all rentals and some purchases.
	Hospice services	No Charge	30% coinsurance after deductible	Requires pre-approval. There is a separate $500 deductible per inpatient stay for out of-network facilities.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit	Not covered	Limited to one exam every calendar year.
	Children's glasses	Not covered	Not covered	———————— none ————————
	Children's dental check-up	Not covered	Not covered	———————— none ————————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long term care
- Private Duty Nursing (Inpatient)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (Pain Management Only)	• Hearing aids (Only for members age 15 or younger, maximums apply	• Routine eye care (Adult)
• Bariatric Surgery (requires pre-approval)	• Infertility treatment (requires pre-approval)	• Non- emergency care when traveling outside of the U.S. (subject to deductible/coinsurance and balance billing)
• Chiropractic Care (limited to 30 visits per calendar year)		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-877-STATENJ (1-877-782-8365). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Aetna at 1-877-782-8365. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebda/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	0%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$400**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	0%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$6,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	0%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

Please note that some of the Limits or Exclusions listed above may be covered under the Prescription Plan.

The plan would be responsible for the other costs of these EXAMPLE covered services.