Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered ServicesCoverNew Jersey State Health Benefits Program: Aetna HMO 2030 (SHBP)Coverage for: A

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?	\$0	See the chart starting on page 2 for how much you pay for covered services. You do not have a plan deductible with this plan.
Are there services covered before you meet your <u>deductible?</u>	Yes. All eligible services except for durable medical equipment and medical appliances.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	Yes. \$100 for medical appliances and durable medical equipment. There are no other specific <u>deductibles</u> .	You do have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ?	For retirees - \$5,999 person/ \$11,998 family.	The <u>out-of-pocket limit</u> 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.
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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-877-STATENJ for a list of <u>network p</u> roviders.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network</u> provider, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (balance <u>billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	Some of the services this plan doesn't cover are listed in this document. See your policy or plan document for additional information about <u>excluded</u> <u>services</u> .

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

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	Not Covered	none	
	<u>Specialist</u> visit	\$30 copay/visit (adult) \$20 copay/visit (child)	Not Covered	Chiropractic care is limited to 20 visits combined per calendar year.	
	Preventive care/screening/ immunization	No Charge	Not Covered	One routine physical per calendar year.	
If you have a tast	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	none	
If you have a test	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	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	Not Covered	none	
	Physician/surgeon fees	No Charge	Not Covered	none	
If you need immediate medical attention	Emergency room care	\$125 copay/visit	\$125 copay/visit	Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.	
	Emergency medical transportation	No Charge	Not Covered	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.	
	Urgent care	\$30 copay/visit (adult) \$20 copay/visit (child)	Not Covered	none	
If you have a hospital	Facility fee (e.g., hospital	No Charge	Not Covered	Requires pre-approval.	

[* For more information about limitations and exceptions, see the plan or policy document at www.state.nj.us/treasury/pensions/health-benefits.shtml or by 2 of 5 calling 1-609-292-7524.]

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Coverage Period: 01/01/2018 – 12/31/2018 Coverage for: All Coverage Types | Plan Type: HMO

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
stay	room)				
	Physician/surgeon fees	No Charge	Not Covered	Requires pre-approval.	
lf you need mental health, behavioral	Outpatient services	\$30 copay/visit (adult) \$20 copay/visit (child)	Not Covered	Some specialty outpatient services require pre-	
health, or substance abuse services	Inpatient services	No Charge	Not Covered	approval. Inpatient services require pre-approval.	
If you are pregnant	Office visits	\$30 copay/visit (adult) \$20 copay/visit (child)	Not Covered	Copayment applies to initial visit only.	
	Childbirth/delivery professional services	No Charge	Not Covered	Requires pre-approval.	
	Childbirth/delivery facility services	No Charge	Not Covered		
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Requires pre-approval.	
	Rehabilitation services	\$30 copay/visit (adult) \$20 copay/visit (child)	Not Covered	Requires pre-approval.	
	Habilitation services	\$30 copay/visit (adult) \$20 copay/visit (child)	Not Covered	Requires pre-approval.	
	Skilled nursing care	No Charge	Not Covered	Requires pre-approval. Limited to 120 days per calendar year.	
	Durable medical equipment	No Charge	Not Covered	Requires pre-approval for all rentals and some purchases. Subject to \$100 medical appliance and durable medical equipment deductible.	
	Hospice services	No Charge	Not Covered	Requires pre-approval.	
If your child needs dental or eye care	Children's eye exam	\$30 copay/visit (adult) \$20 copay/visit (child)	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	

[* For more information about limitations and exceptions, see the plan or policy document at www.state.nj.us/treasury/pensions/health-benefits.shtml or by **3 of 5** calling **1-609-292-7524**.]

Excluded Services & Other Covered Services:			
Services Your Plan Generally Does NOT Cover ((Check your policy or plan document for more informati	ion and a list of any other <u>excluded services</u> .)	
Cosmetic Surgery	Long term care	Routine foot care	
Dental Care (Adult)	Private Duty Nursing (Inpatient)	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 calender)	dar 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 <u>Minimum Essential Coverage</u> 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

[* For more information about limitations and exceptions, see the plan or policy document at www.state.nj.us/treasury/pensions/health-benefits.shtml or by 4 of 5 calling 1-609-292-7524.]



The total Peg would pay is

\$500

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

Peg is Having a Baby (9 months of in-network pre-natal ca hospital delivery)	re and a	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible\$0Specialist copayment\$30Hospital (facility) coinsurance0%Other coinsurance0%		 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> copayment Hospital (facility) coinsurance Other coinsurance 	\$0 \$30 0% 0%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> copayment Hospital (facility) coinsurance Other coinsurance 	\$0 \$30 0% 0%
This EXAMPLE event includes service Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood</i> Specialist visit (<i>anesthesia</i>) Total Example Cost		This EXAMPLE event includes service Primary care physician office visits (<i>inclu</i> <i>disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (glucose me Total Example Cost	ding	This EXAMPLE event includes servi Emergency room care <i>(including medi</i> <i>supplies)</i> Diagnostic test <i>(x-ray)</i> Durable medical equipment <i>(crutches)</i> Rehabilitation services <i>(physical therap</i> Total Example Cost	cal
In this example, Peg would pay:	φ12/101	In this example, Joe would pay:	+ ,	In this example, Mia would pay:	¢1,720
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$40
Copayments	\$400	Copayments	\$200	Copayments	\$200
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$100	Limits or exclusions	\$6,000	Limits or exclusions	\$0

\$6,200

The total Mia would pay is

The total Joe would pay is

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

\$240

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 626-370-4526
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বনিামুল্য 1–800–370–4526–ত েকল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	өдуө s uhadj jhdspdy өtt (CWY) obwøi s 1-800-370-4526 оөт с агдj jegpj hþrө.
Chinese -	欲取得繁體中文語言協助,請撥打 1-800-370-4526,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi <u>I</u> p <u>a</u> ya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French -	Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.

No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.
हनि्दी में भाषा सहायता के लएि, 1-800-370-4526 पर मुफ्त कॉल करें।
Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
လ၊တၢ်မးစၢးတၢ်ကတိးကျိဉ်အဂီၢ် ကိုုဉ် ကိုး 1-800-370-4526 လ၊တအိဉ်ဒီးတၢ်လ၊ာ်ဘူာ်လ၊ာ်စူးဘာဉ်
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오.
Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùduùň wɛ̃ɛ, dá 1-800-370-4526
بر ای راهنمایی به زبان فارسی با شماره 4526-370-800 به خوّر ایی پهیومندی بکهن.
ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशविायकॉलकरा.
Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
សម្ភរាប់ជំនួយភាសាជា ភាសាខ្មមរែ សូមទូរស័ព្ទទទៅកាន់លខេ 1-800-370-4526 ដ ោយឥតគិតថ្ ល។ៃ
T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
(नेपाली) मा नन्शिल्क भाषा सहायता पाउनका लागरि 1-800-370-4526 मा फोन गर्नुहोस् ।
Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.
For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
برای راهنمایی به زبان فارسی با شماره 4526-370-1800 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

- Portuguese Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
- Romanian Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526
- Russian Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
- Samoan Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.
- Serbo-Croatian Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.
- Spanish Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
- Sudanic-Fulfude Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.
- Swahili Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
- Syriac Ka sur range abr Jue r wain or Ju isor 12, 200-370-4526 and 2
- Tagalog -Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
- Telugu భషతో సయం కొరకు ఎలాంటి ఖర్చు లేకుండ 1-800-370-4526 కు కల్ చేయండి. (తెలుగు)
- Thai สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
- Tongan Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā tōtōngi.
- Trukese Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.
- Turkish (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.
- Ukrainian Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
- Vietnamese Đê được hố trở ngôn ngư băng (ngôn ngư), hãy gọi miến phi đên số 1-800-370-4526.
- Yiddish 1-800-370-4526 פריי פון אפצאל.
- Yoruba Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.