⚠️ 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 – Deductible does not apply	First day, first dollar coverage. You do not have to meet a deductible amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services.
Are there services covered before you meet your deductible?	**Yes**. All eligible services.	This plan covers items and services that do not require a deductible to be met.
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?	Yes. For in-network and out-of-network providers $1,000 out of pocket maximum. This is a combined annual maximum for in-network and out-of-network services.	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charge for a Medicare provider who does not accept Medicare Assignment, 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, but not required as long as the provider accepts Medicare. For a list of in-network providers, see http://www.aetnamedicare.com/group/group_plans_intro.jsp or call 1-866-234-3129.	In and out-of-network benefits do not apply to the Medicare PPO ESA plan. However, members need to use a licensed provider with Medicare.
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	$10 copay/visit	$10 copay/visit	——————— none ———————
	Specialist visit	$10 copay/visit	$10 copay/visit	Chiropractic care is limited for manipulation of the spine to the extent covered by Medicare.
	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	No Charge	——————— none ———————
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	——————— none ———————
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	No Charge	——————— none ———————
	Physician/surgeon fees	No Charge	No Charge	——————— none ———————
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.

[* 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**.]

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
New Jersey State Health Benefits Program: Aetna Medicare Advantage PPO ESA 10 (SHBP)

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

aetna®

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)	
	Emergency medical transportation	No Charge	No Charge	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
	Urgent care	$10 copay/visit	$10 copay/visit	––––––––––– none –––––––––––
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	––––––––––– none –––––––––––
	Physician/surgeon fees	No Charge	No Charge	––––––––––– none –––––––––––
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	$10 copay/visit	––––––––––– none –––––––––––
	Inpatient services	No Charge	No Charge	
If you are pregnant	Office visits	$10 copay/visit	$10 copay/visit	Copayment applies to initial visit only.
	Childbirth/delivery professional services	No Charge	No Charge	Requires pre-approval.
	Childbirth/delivery facility services	No Charge	No Charge	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Requires pre-approval.
	Rehabilitation services	$10 copay/visit	$10 copay/visit	Requires pre-approval.
	Habilitation services	$10 copay/visit	$10 copay/visit	Requires pre-approval.
	Skilled nursing care	No Charge	No Charge	Requires pre-approval. Limited to 120 days.
	Durable medical equipment	No Charge	No Charge	Requires pre-approval for all rentals and some purchases.
	Hospice services	No Charge	No Charge	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 calling **1-609-292-7524**.]

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information 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 <u>plan</u> document.)		
• Acupuncture (Pain Management Only)	• Prosthetic devices	• 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		

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>.

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

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)*

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)*

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	$12,731

Total Example Cost	$7,389

Total Example Cost	$1,925

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$120**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$696
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$751**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$70**

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

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.

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 እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526

Armenian - Լեզվի շււգարերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց զնով:

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 বিনামূল্যে 1-800-370-4526-তে 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 - ᏗᎣᏴᎦ ᏚᎳᎯᎭᎥᎠᏗ ᏗᎻᏍᎦᎵᏒᎠᏴ ᎤᏟᎢ (ᏣᏩ) ᎤᏓᏪᎸᎢᏍ 1-800-370-4526 ᎤᏣᎢ Ꮮ ᎠᎦᏍᎠ ᏧᎬᎱᏒᎠ �复ᎡᎢ.

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 ya apela a chi I paya 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.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ़्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese -	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。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိၣ်အဂီၢ် ကျိၣ် ကံး 1-800-370-4526 လၢတအိၣ်ဒီးတၢ်လၢာ်ဘူၣ်လၢာ်စ့ၤဘၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m̀ké gbo-kpá-kpá dyé pidyi dé Ɓaˇsɔɔ̀-wuɖuǔn wɛɛ̀, ɖá 1-800-370-4526
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅ ៏ាកាន់លេខ 1-800-370-4526 ដៃ៚ាយឥតគិតថ្លៃ៕
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	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 asistenţă lingvistică în româneşte telefonaţi 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 - ܠܥܘܕܪܢܐ 1-800-370-4526 ܩܪܘ،ܠܡܝܢܐ ܐܝܟ ܠܫܢܐ ܣܘܪܝܝܐ ܐܘ ܐܪܡܝܐ ܠܝܬ ܒܗ ܛܝܡܐ ܕܠܐ ܬܫܡܝܐ ܐܦ ܕܠܐ ܐܓܪܐ.

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండ 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau ʻoku fiemaʻu hā tokoni ʻi he lea faka-Tonga telefoni 1-800-370-4526 ʻo ʻikai 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.

Urdu - اردو میں لسانی اعانت و تنکیک کے لیے 1-800-370-4526 پر مفت کال کریں ا

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 láì san owó kankan rárá.