



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, [www.MembersHealthPlanNJ.com](http://www.MembersHealthPlanNJ.com) or by calling 1-833-982-7368. 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 1-833-982-7368 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| <b>What is the overall <u>deductible</u>?</b>                             | In- <u>Network</u> : Individual \$3,000 / Family \$6,000.   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. In- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .                           | 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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>  |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.   | You don't have to meet <u>deductibles</u> for specific services.  |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | In- <u>Network</u> : Individual \$6,000 / Family \$12,000.  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-833-982-7368 for a list of in- <u>network providers</u> . | 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 network</u> . You will pay the most if you use an <u>out-of-network provider</u> , 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 ( <u>balance 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No.   | You can see the <u>specialist</u> you choose without a <u>referral</u> .  |



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   |
|--|---|--|--|--|
|  |   | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(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        | \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except after <u>deductible</u> , 20% <u>coinsurance</u> for office surgery  | Not covered  | None   |
|  | <u>Specialist</u> visit                                 | \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except after <u>deductible</u> , 20% <u>coinsurance</u> for office surgery  | Not covered  | None   |
|  | <u>Preventive care</u> / <u>screening</u> /immunization | No charge  | Not covered  | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.                |
| If you have a test                                     | <u>Diagnostic test</u> (x-ray, blood work)              | Lab: \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply-office based/freestanding; after <u>deductible</u> , 20% <u>coinsurance</u> for hospital/facility;<br>X-ray: after <u>deductible</u> , 20% <u>coinsurance</u> | Not covered  | None   |
|  | Imaging (CT/PET scans, MRIs)                            | After <u>deductible</u> , 20% <u>coinsurance</u>   | Not covered  | <u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$10,000 of the total <u>allowed amount</u> of the service. |

| Common Medical Event  | Services You May Need     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|---------------------------|--|--|--|
|   |                           | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a> | Generic drugs             | <b>RX1</b> - \$15 <u>copay</u> / prescription (retail), \$35 <u>copay</u> / prescription (mail order)<br><b>RX2</b> - \$30 <u>copay</u> / prescription (retail), \$70 <u>copay</u> / prescription (mail order)<br><b>RX3</b> - \$15 <u>copay</u> / prescription (retail), \$37.50 <u>copay</u> / prescription (mail order)<br><b>RX6</b> - Not covered | Not covered  | Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); Retail Refill Allowance, Step Therapy or Dispense as Written may apply.   |
|   | Preferred brand drugs     | <b>RX1</b> - \$35 <u>copay</u> / prescription (retail), \$82.50 <u>copay</u> / prescription (mail order)<br><b>RX2</b> - \$50 <u>copay</u> / prescription (retail), \$120 <u>copay</u> / prescription (mail order)<br><b>RX3</b> - 50% <u>coinsurance</u> / prescription (retail & mail order)<br><b>RX6</b> - Not covered                             | Not covered  | Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); Retail Refill Allowance, Step Therapy or Dispense as Written may apply.<br><br><b>RX3</b> - (Retail) minimum on 30-day supply is \$25; maximum \$500. (Mail order) minimum on 90-day supply is \$62.50; maximum \$1,250. Applies to Preferred, Non-preferred and <u>Specialty drugs</u> . |
|   | Non-preferred brand drugs | <b>RX1</b> - \$50 <u>copay</u> / prescription (retail), \$120 <u>copay</u> / prescription (mail order)<br><b>RX2</b> - \$80 <u>copay</u> / prescription (retail), \$195 <u>copay</u> / prescription (mail order)<br><b>RX3</b> - 50% <u>coinsurance</u> / prescription (retail & mail order)<br><b>RX6</b> - Not covered                               | Not covered  | Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); Retail Refill Allowance, Step Therapy or Dispense as Written may apply.<br><br><b>RX3</b> - (Retail) minimum on 30-day supply is \$25; maximum \$500. (Mail order) minimum on 90-day supply is \$62.50; maximum \$1,250. Applies to Preferred, Non-preferred and <u>Specialty drugs</u> . |

| Common Medical Event   | Services You May Need                          | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|--|--|---|--|--|
|  |  | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)                       |  |
| <p><b>If you need drugs to treat your illness or condition</b><br/>More information about <a href="http://www.Express-Scripts.com">prescription drug coverage</a> is available at <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a></p> | Specialty drugs                                | <p><b>RX1</b>- \$35-\$50 <u>copay</u> / prescription (retail), \$82.50-\$120 <u>copay</u> / prescription (mail order)<br/> <b>RX2</b>- \$50-\$80 <u>copay</u> / prescription (retail), \$120-\$195 <u>copay</u> / prescription (mail order)<br/> <b>RX3</b>- 50% <u>coinsurance</u> / prescription (retail &amp; mail order)<br/> <b>RX6</b>- Not covered</p> | Not covered  | <p>Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); Retail Refill Allowance, Step Therapy or Dispense as Written may apply.</p> <p><b>RX3</b> - (Retail) minimum on 30-day supply is \$25; maximum \$500. (Mail order) minimum on 90-day supply is \$62.50; maximum \$1,250. Applies to Preferred, Non-preferred and <u>Specialty drugs</u>. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximum.</p> |
| <p><b>If you have outpatient surgery</b></p>   | Facility fee (e.g., ambulatory surgery center) | After <u>deductible</u> , 20% <u>coinsurance</u>  | Not covered  | <u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$10,000 of the total <u>allowed amount</u> of the service.   |
|  | Physician/surgeon fees                         | After <u>deductible</u> , 20% <u>coinsurance</u>  | Not covered  | None   |
| <p><b>If you need immediate medical attention</b></p>  | <u>Emergency room care</u>                     | After <u>deductible</u> , \$100 copay/visit, then 20% <u>coinsurance</u>  | After <u>deductible</u> , \$100 copay/visit, then 20% <u>coinsurance</u> | No coverage for non-emergency use  |
|  | <u>Emergency medical transportation</u>        | After <u>deductible</u> , 20% <u>coinsurance</u>  | After <u>deductible</u> , 20% <u>coinsurance</u>                         | Non-emergency transport: not covered, except if pre-authorized.  |
|  | <u>Urgent care</u>                             | \$50 <u>copay</u> /visit  | \$50 <u>copay</u> /visit   | No coverage for non-urgent use.  |
| <p><b>If you have a hospital stay</b></p>  | Facility fee (e.g., hospital room)             | After <u>deductible</u> and \$500 <u>copay</u> /stay, then 20% <u>coinsurance</u>   | Not covered  | <u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$10,000 of the total <u>allowed amount</u> of the service.   |
|  | Physician/surgeon fees                         | After <u>deductible</u> , 20% <u>coinsurance</u>  | Not covered  | None   |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|---|---|--|--|
|   |   | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office: \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply;<br>All other outpatient: After <u>deductible</u> , 20% <u>coinsurance</u>          | Not covered  | None   |
|   | Inpatient services                        | After <u>deductible</u> and \$500 <u>copay</u> /stay, then 20% <u>coinsurance</u>   | Not covered  | <u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$10,000 of the total <u>allowed amount</u> of the service.   |
| If you are pregnant   | Office visits                             | No charge; except \$30 <u>copay</u> for initial visit to confirm pregnancy, <u>deductible</u> doesn't apply   | Not covered  | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$10,000 of the total <u>allowed amount</u> of the service. |
|   | Childbirth/delivery professional services | After <u>deductible</u> , 20% <u>coinsurance</u>  | Not covered  |  |
|   | Childbirth/delivery facility services     | After <u>deductible</u> and \$500 <u>copay</u> /stay, 20% <u>coinsurance</u>  | Not covered  |  |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | After <u>deductible</u> , 20% <u>coinsurance</u>  | Not covered  | 60 visits/calendar year. <u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$10,000 of the total <u>allowed amount</u> of the service.  |
|   | <u>Rehabilitation services</u>            | Office/freestanding: \$50 <u>copay</u> /visit <u>deductible</u> doesn't apply;<br>Hospital/facility: after <u>deductible</u> , 20% <u>coinsurance</u> | Not covered  | 60 visits/calendar year for Physical, Occupational & Speech Therapy combined. <u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$10,000 of the total <u>allowed amount</u> of the service.   |
|   | <u>Habilitation services</u>              | Office: \$30 <u>copay</u> /visit; <u>deductible</u> doesn't apply   | Not covered  | Limited to treatment of Autism.  |
| If you need help recovering or have other special health needs            | <u>Skilled nursing care</u>               | After <u>deductible</u> and \$500 <u>copay</u> /stay, then 20% <u>coinsurance</u>   | Not covered  | 60 days/incident. <u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$10,000 of the total <u>allowed amount</u> of the service.   |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                |  | Limitations, Exceptions, & Other Important Information   |
|--|----------------------------------|--|--|--|
|  |                                  | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
|  | <u>Durable medical equipment</u> | After <u>deductible</u> , 20% <u>coinsurance</u> | Not covered  | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.   |
|  | <u>Hospice services</u>          | After <u>deductible</u> , 20% <u>coinsurance</u> | Not covered  | <u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$10,000 of the total <u>allowed amount</u> of the service. |
| If your child needs dental or eye care | Children's eye exam              | No charge  | Not covered  | 1 routine eye exam/calendar year.  |
|  | Children's glasses               | Amounts greater than \$125.00.                   | Amounts greater than \$125.00.                     | Coverage limited to one pair of glasses/year.  |
|  | Children's dental check-up       | Not covered                                      | Not covered  | Not covered.   |

#### 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 & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

##### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (in lieu of anesthesia)
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/24 months for children up to age 15.
- Infertility treatment - Limited to diagnosis, artificial insemination, and ovulation induction.
- Private-duty nursing – 70- 8 hour shifts/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/calendar year for Tier 1 only.

### **Your Rights to Continue Coverage:**

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-833-982-7368 .
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or : <https://www.dol.gov/agencies/ebsa>

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

### **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-833-982-7368 .
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at:  
<http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

### **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 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.

### **Language Assistance: For language assistance in your language call 1-833-982-7368 at no cost.**

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-982-7368

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-982-7368

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-982-7368

-----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 <u>plan's</u> overall <u>deductible</u> | \$3,000 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$50    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

#### 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*)

|  |                 |
|--|-----------------|
| <b>Total Example Cost</b>              | <b>\$13,478</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| Deductibles                            | \$3,000         |
| Copayments                             | \$1,140         |
| Coinsurance                            | \$1,825         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$6,025</b>  |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|   |         |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$3,000 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$50    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

#### 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*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$7,811</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| Deductibles                            | \$3,000        |
| Copayments                             | \$1,740        |
| Coinsurance                            | \$346          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$346          |
| <b>The total Joe would pay is</b>      | <b>\$5,141</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|   |         |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$3,000 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$50    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$1,934</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| Deductibles                            | \$1,133        |
| Copayments                             | \$350          |
| Coinsurance                            | \$283          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$1,766</b> |

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 1-833-982-7368 .

### **Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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