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 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:
What is the overall deductible?	In-Network: Individual $500 / Family $1,000. Out-of-Network: Individual $1,500 / Family $3,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $6,850 / Family $13,700. Out-of-Network: Individual $6,850 / Family $13,700.	The out–of–pocket limit is the most you could pay in a year for covered services. 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-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	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 1-833-982-7368 for a list of in-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
		In-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	$30 copay/visit, deductible doesn't apply; except for office surgery, after deductible, 10% coinsurance	After deductible, 30% coinsurance	None
	Specialist visit	$50 copay/visit, deductible doesn't apply; except for office surgery, after deductible, 10% coinsurance.	After deductible, 30% coinsurance	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: $30 copay/visit-office/freestanding, deductible doesn't apply; After deductible, 10% coinsurance-hospital/facility; X-ray: After deductible, 10% coinsurance	After deductible, 30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	After deductible, 10% coinsurance	After deductible, 30% coinsurance	Pre-authorization may be required. If you don't get pre-authorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Generic drugs	**RX1**- $15 copay / prescription (retail), $35 copay / prescription (mail order) **RX2**- $25 copay / prescription (retail), $60 copay / prescription (mail order) **RX3**- $15 copay / prescription (retail), $37.50 copay / prescription (mail order) **RX6**- Not covered	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); Maintenance Medications- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. Dispense as Written may apply.
	Preferred brand drugs	**RX1**- $50 copay / prescription (retail), $125 copay / prescription (mail order) **RX2**- $75 copay / prescription (retail), $187.50 copay / prescription (mail order) **RX3**- 50% coinsurance / prescription (retail & mail order) **RX6**- Not covered	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); Maintenance Medications- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. Dispense as Written may apply. **RX3** - (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 and Non-preferred drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Non-preferred brand drugs	**RX1**- $75 copay / prescription (retail), $187.50 copay / prescription (mail order) **RX2**- $100 copay / prescription (retail), $250 copay / prescription (mail order) **RX3**- 50% coinsurance / prescription (retail & mail order) **RX6**- Not covered	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); Maintenance Medications- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. Dispense as Written may apply. **RX3** - (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 and Non-preferred drugs.
	Specialty drugs	**RX1**- 30% coinsurance / prescription (retail & mail order) **RX2**- 30% coinsurance / prescription (retail & mail order) **RX3**- 50% coinsurance / prescription (retail & mail order) **RX6**- Not covered	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); Maintenance Medications- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. Dispense as Written may apply. 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. All prescriptions must be filled through the Aetna Specialty Performance Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After deductible, 10% coinsurance	After deductible, 30% coinsurance	Pre-authorization may be required. If you don't get pre-authorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	After deductible, 10% coinsurance	After deductible, 30% coinsurance	None
If you need immediate medical attention	Emergency room care	After deductible, and $100 copay/visit, 10% coinsurance	After deductible, and $100 copay/visit, 10% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	After deductible, 10% coinsurance	After deductible, 10% coinsurance	Non-emergency transport: not covered, except 30% coinsurance if pre-authorized.
	Urgent care	$50 copay/visit	$50 copay/visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible, 10% coinsurance	After deductible, 30% coinsurance	Pre-authorization may be required. If you don't get pre-authorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
	Physician/surgeon fees	After deductible, 10% coinsurance	After deductible, 30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $30 copay/visit, deductible doesn't apply; All other outpatient: after deductible, 10% coinsurance	After deductible, 30% coinsurance	None
	Inpatient services	After deductible, 10% coinsurance	After deductible, 30% coinsurance	Pre-authorization may be required. If you don't get pre-authorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
If you are pregnant	Office visits	No charge except $30 copay for initial visit to confirm pregnancy	After deductible, 30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization may be required. If you don't get pre-authorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service may apply.
	Childbirth/delivery professional services	After deductible, 10% coinsurance	After deductible, 30% coinsurance	
	Childbirth/delivery facility services	After deductible, 10% coinsurance	After deductible, 30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	After deductible, 10% coinsurance	Not covered	60 visits/calendar year. Pre-authorization may be required. If you don't get pre-authorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
If you need help recovering or have other special health needs	Rehabilitation services	$50 copay/visit, deductible doesn't apply in office/ freestanding; After deductible, 10% coinsurance- hospital/facility	After deductible, 30% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined. Pre-authorization may be required. If you don't get pre-authorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
	Habilitation services	$30 copay/visit, deductible doesn't apply	After deductible, 30% coinsurance	Limited to treatment of Autism.
	Skilled nursing care	After deductible, 10% coinsurance	After deductible, 30% coinsurance	60 days/incident. Pre-authorization may be required. If you don't get pre-authorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
	Durable medical equipment	After deductible, 10% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	After deductible, 10% coinsurance	After deductible, 30% coinsurance	Pre-authorization may be required. If you don't get pre-authorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount 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	1 pair of glasses/calendar 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 for in-network only.	• 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 for in-network only. • Routine eye care (Adult) - 1 routine eye exam/calendar year for in-network 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 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 lingüística en español, llame sin cargo al 1-833-982-7368
Tagalog (Tagalog): Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-833-982-7368 nang walang bayad
Chinese (中文): 欲取得繁體中文語言協助，請撥打 1-833-982-7368，無需付費。

----------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	**$500**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**10%**
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	**$13,478**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$1,140
Coinsurance	$912
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,612**

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

The plan's overall deductible	**$500**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**10%**
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	**$7,811**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$1,740
Coinsurance	$173
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,468**

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

The plan's overall deductible	**$500**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**10%**
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	**$2,001**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$650
Coinsurance	$86
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,236**

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.

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).