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	$15 copay/visit	$15 copay/visit	———— none ————
	Specialist visit	$15 copay/visit	$15 copay/visit	Unlimited visits for chiropractic services for subluxation of the spine. Other services within the scope of the chiropractor's license, have a 30 visit limit per year.
	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.
	Emergency medical	No Charge	No Charge	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.

[* 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.]

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)	
	transportation			
	Urgent care	$15 copay/visit	$15 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	$15 copay/visit	$15 copay/visit	———— none ————
	Inpatient services	No Charge	No Charge	
If you are pregnant	Office visits	$15 copay/visit	$15 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	$15 copay/visit	$15 copay/visit	Requires pre-approval.
	Habilitation services	$15 copay/visit	$15 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.

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

[* 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.]

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

[* 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.]

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	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*)

Total Example Cost	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$130

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	0%

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	$746
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$801

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	0%

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	$105
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$105

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