**Important Questions** | **Answers** | **Why This Matters:**
---|---|---
What is the overall deductible? | For each Plan Year, In-Network: Individual $150. Out-of-Network: Individual $1,000. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible? | Yes. Prescription drugs; plus in-network 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/](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 $5,000. Out-of-Network: Individual $10,000. | The out–of–pocket limit is the most you could pay in a year for covered services.
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 1-800-481-8814 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.
## Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td><strong>In-Network Provider</strong> (You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 copay/visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$30 copay/visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>50% coinsurance, except deductible doesn't apply to child immunizations</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td><strong>Diagnostic test (x-ray, blood work)</strong></td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Imaging (CT/PET scans, MRIs)</strong></td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td><strong>Generic drugs</strong></td>
<td>50% coinsurance after copay/ prescription, deductible doesn't apply: $20 (retail &amp; mail order)</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred brand drugs</strong></td>
<td>50% coinsurance after copay/ prescription, deductible doesn't apply: $40 (retail &amp; mail order)</td>
</tr>
<tr>
<td></td>
<td><strong>Non-preferred brand drugs</strong></td>
<td>50% coinsurance after copay/ prescription, deductible doesn't apply: $40 (retail &amp; mail order)</td>
</tr>
<tr>
<td></td>
<td><strong>Specialty drugs</strong></td>
<td>Not covered</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at https://www.aetna.com/individuals-families/pharmacy.html
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Provider (You will pay the least)</th>
<th>What You Will Pay Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td>attention</td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $30 copay/visit; other outpatient services: 20% coinsurance</td>
<td>Office &amp; other outpatient services: 50% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25 copay/visit</td>
<td>50% coinsurance</td>
<td>Includes Physical, Occupational &amp; Speech Therapy. Penalty of $500 for failure to obtain pre-authorization for out-of-network care. Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$25 copay/visit</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>1 routine eye exam/plan year up to age 19.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>1 pair of glasses or lenses/plan year.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

**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.)**

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- 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
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/plan year.
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing – Limited to in-network providers.

**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: Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Phone: 1-888-393-1062 or Consumer Hotline: 1-800-446-7467, [http://www.state.nj.us/dobi/consumer.htm](http://www.state.nj.us/dobi/consumer.htm).

- For more information on your rights to continue coverage, contact the plan at 1-800-481-8814.
- State Consumer Assistance Program, if other than state insurance department contact New Jersey Department of Banking and Insurance, 20 West State Street, P.O. Box 325, Trenton, NJ 08625, (800) 446-7467, (609) 292-7272, [http://www.state.nj.us/dobi/consumer.htm](http://www.state.nj.us/dobi/consumer.htm), ombudsman@dobi.state.nj.us

**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 1-800-481-8814.
- Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Phone: 1-888-393-1062 or Consumer Hotline: 1-800-446-7467, [http://www.state.nj.us/dobi/consumer.htm](http://www.state.nj.us/dobi/consumer.htm).
Additionally, a consumer assistance program can help you file your appeal. Contact New Jersey Department of Banking and Insurance, 20 West State Street, P.O. Box 225, Trenton, NJ 08625, (800) 445-7467, (609) 292-7272, http://www.state.nj.us/dobi/consumer.htm, ombudsman@dobi.state.nj.us

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.

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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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
</tr>
</tbody>
</table>

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 | $12,800 |
| Total Example Cost | $7,400 |
| Total Example Cost | $1,900 |

In this example, Peg would pay:

| Cost Sharing | $150 |
| Deductibles | $150 |
| Copayments | $100 |
| Coinsurance | $2,400 |

In this example, Joe would pay:

| Cost Sharing | $150 |
| Deductibles | $150 |
| Copayments | $1,800 |
| Coinsurance | $10 |

In this example, Mia would pay:

| Cost Sharing | $150 |
| Deductibles | $150 |
| Copayments | $100 |
| Coinsurance | $200 |

The total Peg would pay is $2,710

The total Joe would pay is $1,980

The total Mia would pay is $450

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 1-800-481-8814.

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, 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).

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 1-800-481-8814 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-481-8814.
Amharic - እንጆች እግርስ በ እንወር ይ ከ 1-800-481-8814 ለአምርሮ ከተሠቀ መንክር ለማሸፋ ወቅት ይታገሩ
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-481-8814.
Armenian - Ծառայություն ու ինֆորմացիա կարելի է ստանալ 1-800-481-8814 համար.
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-481-8814 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-481-8814 ku busa.
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-481-8814 -তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-481-8814 nga walay bayad.
Burmese - မိုးမိုးရွေးချယ်ပါသည်။ 1-800-481-8814 ကို လည်ပတ်ပါ။
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-481-8814.
Chamorro - Para ayuda gi fino’ (Chamoru), ágang 1-800-481-8814 sin gástu.
Cherokee - ᏰᎦᏯᏫ ᎠᏯᏣ.ᎣᏳ.egov.Ꭳ bathtub (GWV) ᏤᎣᏳis 1-800-481-8814 ᏭᏣ的数量 a ᏣᏫ.Ꭳ ᏣᏫenthal.
Chinese - 欲取得繁體中文語言協助，請撥打 1-800-481-8814，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-481-8814.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuul lakkokkofaa bilbilaa 1-800-481-8814 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-481-8814.
French - Pour une assistance linguistique en français appeler le 1-800-481-8814 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-481-8814 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-481-8814 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-481-8814 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં યાદીમાં સહાય માટે ટોલ નંબર 1-800-481-8814 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-481-8814. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-481-8814 पर मुफ्त कॉल करें।
Hmong - Maka enyemaka asusu na Igbo kpoo 1-800-481-8814 na akwughi ugwo o bula
Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-481-8814 nga awan ti bayadanyo.
Ilocano - Per riceverre assistenza linguistica in italiano, puo’ chiamare gratuitamente 1-800-481-8814.
Japanese - 日本語で援助をご希望の方は、1-800-481-8814 まで無料でお電話ください。
Karen - ယာနိုင်ငံတော် ကြိုးကျင်မှု့စ်မှု နှင့် ပြည်သူဌာနစ်ဒီဇိုင်း 1-800-481-8814 ကို သိမ်းချင်ပါသည်။
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-481-8814 번으로 전화해 주십시오.
Kru-Bassa - Be’m ké gbo-kpá-kpá dyé pidji dë Basso-wuquün wëc, dë 1-800-481-8814
Kurdish - برای راهنمایی به زبان فارسی، با شماره 1-800-481-8814 به دوچرخه بکن.
Laotian - ໄປສະທາລະນາໄປສະໝດໜາບາາລາວ 1-800-481-8814 ຂໍ້ຕໍ່ເລົ່າຊີກ.
Marathi - तीलभाषा (मराठी) सहायता केंद्र 1-800-481-8814 कमांडरकवकोणत्याहीखाचिकसायकोलकरा.
Marshallese - Ñan bök jipañ ilo Kajin Majol, kallok 1-800-481-8814 ilo ejelok wönän.
Micronesian-Pohnpeyan - Ohng palien sawas en souw kawewe ni omw lokaia Ponape koahl 1-800-481-8814 ni sohete isais.
Mon-Khmer, - Khmer - សិស្សាប់ប្រៀបធៀបនឹងសារឈ្មោះប្រការី 1-800-481-8814 ។ សិស្សខ្លាំងត្រូវបានជួសជុល។
Cambodian - T'áá shi shiaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jík'e hólne' 1-800-481-8814
Nepali - (नेपाली) मा नि:शुल्क भाषा सहायता पाउनका मार्गमा 1- 800-481-8814 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tên kuwoony ê thok ê Thuonjân cël 1-800-481-8814 kecin ayóc.
Norwegian - For språkassitansse på norsk, ring 1-800-481-8814 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਦਿੱਚ ਭਾਸ਼ੀ ਮਾਦਿਨ ਲਈ, 1-800-481-8814 'ਤੇ ਮੁੱਢੁ ਧਰੁ ਵਰਤੋਂ।
Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-481-8814 aa. Es Aaruf koschtet nix.
Persian - برای راهنمایی به زبان فارسی با شماره 1-800-481-8814 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-481-8814.
Para obter assistência linguística em português ligue para o 1-800-481-8814 gratuitamente.

Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-481-8814.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-481-8814.

Mo fesoasoani tau gagana l le Gagana Samoa vala'au le 1-800-481-8814 e aunoa ma se totopi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-481-8814.

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-481-8814.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-481-8814. Njodi woo fawaaki on.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-481-8814 nang walang bayad.

Mo 1-800-481-8814 έργο ervation άρω ίσως λαμα 3 ονόμα της. (Syriac)

สำหรับความช่วยเหลือทางภาษาเป็นภาษาไทย โทร 1-800-481-8814 ฟรีไม่มีค่าใช้จ่าย.

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-481-8814 ’o ‘ikai hā ọtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-481-8814 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-481-8814.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-481-8814.

De được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hay gọi miễn phí điện số 1-800-481-8814.

Fún irànlowọ nípa èdè (Yorùbá) pe 1-800-481-8814 lái san owó kankan rárá.