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, visit www.apehp.com or call 1-888-670-8135. 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 www.apehp.com or call 1-888-670-8135 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out of Network: $2,500 person/$5,000 family	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. Preventive care services 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?	Yes. In Network: $2,500 person/$5,000 family facility deductible	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers and out-of-network providers combined- $6,850 person / $13,700 family	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, 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. See www.apehp.com or call 1-888-670-8135 for a list of network providers. For outside NJ, www.sarhcpdir.cigna.com/mcoap or call 1-888-670-8135.	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
		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 /office visit	30% coinsurance	None
	Specialist visit	$15 copay /visit	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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	Preauthorization is required. If you don't get preauthorization, 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
		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.Express-Scripts.com	Generic drugs	**RX1**- $6 copay / prescription (retail), $15 copay / prescription (mail order) **RX2**- $20 copay / prescription (retail), $50 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); Retail Refill Allowance, Step Therapy or Dispense as Written may apply.
	Preferred brand drugs	**RX1**- $25 copay / prescription (retail), $62.50 copay / prescription (mail order) **RX2**- $40 copay / prescription (retail), $100 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); Retail Refill Allowance, Step Therapy or 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, Non-preferred and Specialty drugs.
	Non-preferred brand drugs	**RX1**- $40 copay / prescription (retail), $100 copay / prescription (mail order) **RX2**- $70 copay / prescription (retail), $175 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); Retail Refill Allowance, Step Therapy or 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, Non-preferred and Specialty drugs.
	Specialty drugs	**RX1**- $25-$40 copay / prescription (retail), $62.50-$100 copay / prescription (mail order) **RX2**- $40-$70 copay / prescription (retail),	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. **RX3** - (Retail) minimum on 30 day supply is

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)	
		$100-$175 copay / prescription (mail order) **RX3**- 50% coinsurance / prescription (retail & mail order) **RX6**- Not covered		$25; maximum $500. (Mail order) minimum on 90 day supply is $62.50; maximum $1,250. Applies to Preferred, Non-preferred and Specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service. Out of network only: $1,000 maximum allowed amount at ambulatory surgery centers.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$50 copay /visit	$50 copay /visit	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$15 copay /visit	$15 copay /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay /visit-office or freestanding facility No charge-hospital	30% coinsurance	None
	Inpatient services	No charge	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
If you are pregnant	Office visits	$15 copay (initial visit only), then no charge	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply.
	Childbirth/delivery professional services	No charge	30% coinsurance	None

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)	
	Childbirth/delivery facility services	No charge	30% coinsurance	Preauthorization is required. If you don't get preauthorization, 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	Home health care	No charge	Not covered	60 visits/year Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
	Rehabilitation services	$15 copay /visit-office or freestanding facility No charge-hospital	30% coinsurance	60 visits/year combined Includes physical therapy, speech therapy, and occupational therapy. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	30% coinsurance	60 visits/incident Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
	Durable medical equipment	No charge	Not covered	Excludes vehicle modifications, home modifications, exercise equipment. Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by 50% up to $10,000 of the total allowed amount of the service.
	Hospice services	No charge	30% coinsurance	Preauthorization is required. If you don't get preauthorization, 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	Coverage limited to one exam/year.
	Children's glasses	50% coinsurance	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	Not covered	Not covered	None

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)
- Dental Care (Child)
- Habilitation services
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Weight Loss Programs

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
- Hearing Aids (Child)
- Infertility Treatment
- Private Duty Nursing
- Routine eye care (Adult)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: The Plan at 1-888-670-8135 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the New Jersey Department of Banking and Insurance at 1-800-446-7467 or www.state.nj.us/dobi/consumer.htm.

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 Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-670-8135.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-670-8135.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-888-670-8135.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-670-8135.

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	$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	**$12,971**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$309
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,869**

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	$661
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$716**

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**