




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](http://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](http://www.apehp.com) or call 1-888-670-8135 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In Network: \$5,000 person / \$10,000 family Out of Network: \$5,000 person / \$10,000 family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You Don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> \$6,850 person / \$13,700 family and <a href="#">out-of-network providers</a> \$13,700 person / \$27,400 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.apehp.com">www.apehp.com</a> or call 1-888-670-8135 for a list of <a href="#">network providers</a> . For outside NJ, <a href="http://www.sarhpcdir.cigna.com/mcoap">www.sarhpcdir.cigna.com/mcoap</a> or call 1-888-670-8135.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$50 <a href="#">copay</a> /office visit	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total <a href="#">allowed amount</a> 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)	
<p><b>If you need drugs to treat your illness or condition</b> 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>	Generic drugs	<p><b>RX1</b>- \$6 <a href="#">copay</a> / prescription (retail), \$15 <a href="#">copay</a> / prescription (mail order)  <b>RX2</b>- \$20 <a href="#">copay</a> / prescription (retail), \$50 <a href="#">copay</a> / prescription (mail order)  <b>RX3</b>- \$15 <a href="#">copay</a> / prescription (retail), \$37.50 <a href="#">copay</a> / prescription (mail order)  <b>RX6</b>- Not covered</p>	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	<p><b>RX1</b>- \$25 <a href="#">copay</a> / prescription (retail), \$62.50 <a href="#">copay</a> / prescription (mail order)  <b>RX2</b>- \$40 <a href="#">copay</a> / prescription (retail), \$100 <a href="#">copay</a> / prescription (mail order)  <b>RX3</b>- 50% <a href="#">coinsurance</a> / prescription (retail &amp; mail order)  <b>RX6</b>- Not covered</p>	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.  <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 <a href="#">Specialty drugs</a> .
	Non-preferred brand drugs	<p><b>RX1</b>- \$40 <a href="#">copay</a> / prescription (retail), \$100 <a href="#">copay</a> / prescription (mail order)  <b>RX2</b>- \$70 <a href="#">copay</a> / prescription (retail), \$175 <a href="#">copay</a> / prescription (mail order)  <b>RX3</b>- 50% <a href="#">coinsurance</a> / prescription (retail &amp; mail order)  <b>RX6</b>- Not covered</p>	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.  <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 <a href="#">Specialty drugs</a> .
	<a href="#">Specialty drugs</a>	<p><b>RX1</b>- \$25-\$40 <a href="#">copay</a> / prescription (retail), \$62.50-\$100 <a href="#">copay</a> / prescription (mail order)  <b>RX2</b>- \$40-\$70 <a href="#">copay</a> / prescription (retail),</p>	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.  <b>RX3</b> - (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 <a href="#">copay</a> / prescription (mail order) <b>RX3</b> - 50% <a href="#">coinsurance</a> / prescription (retail & mail order) <b>RX6</b> - Not covered		\$25; maximum \$500. (Mail order) minimum on 90 day supply is \$62.50; maximum \$1,250. Applies to Preferred, Non-preferred and <a href="#">Specialty drugs</a> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total <a href="#">allowed amount</a> of the service. Out of network only: \$1,000 maximum <a href="#">allowed amount</a> at ambulatory surgery centers.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total <a href="#">allowed amount</a> of the service.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <a href="#">copay</a> /visit-office 20% <a href="#">coinsurance</a> - hospital or freestanding facility	50% <a href="#">coinsurance</a>	None
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total <a href="#">allowed amount</a> of the service.
If you are pregnant	Office visits	\$50 <a href="#">copay</a> (initial visit only), then no charge	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total <a href="#">allowed amount</a> of the service.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	60 visits/year <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total <a href="#">allowed amount</a> of the service.
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copay</a> /visit-office, 20% <a href="#">coinsurance</a> - hospital or freestanding facility	50% <a href="#">coinsurance</a>	60 visits/year combined Includes physical therapy, speech therapy, and occupational therapy. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total <a href="#">allowed amount</a> of the service.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	60 visits/incident <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total <a href="#">allowed amount</a> of the service.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	Excludes vehicle modifications, home modifications, exercise equipment. <a href="#">Preauthorization</a> may be required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total <a href="#">allowed amount</a> of the service.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% up to \$10,000 of the total cost 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% <a href="#">coinsurance</a>	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](http://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](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: 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](http://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](http://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, kwijigo 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](#) \$5,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>\$13,532</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$974
Coinsurance	\$1,825
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,859</b>

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>\$7,389</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$5,000
Copayments	\$1,011
Coinsurance	\$346
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$6,412</b>

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>
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**In this example, Mia would pay:**

<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>