




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.dol.gov/ebsa/healthreform or call 1-888-670-8135 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | In Network: \$3,000 person / \$6,000 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? | No | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | For network providers \$6,000 person / \$12,000 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.qualcareinc.com/FindADoctor/FindADoctor_QCGeneric.aspx 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 | \$30 copay /office visit | Not covered | None |
| | Specialist visit | \$50 copay /visit | Not covered | 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) | 20% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | 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. |

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|--|---------------------------------|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| <p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Express-Scripts.com and www.apehp.com/forms-documents</p> | 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), | Not covered | Covers up to a 30-day supply (retail prescription); 90 day supply (mail order |

| 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) | |
| | | \$62.50-\$100 copay / prescription (mail order) RX2 - \$40-\$70 copay / prescription (retail), \$100-\$175 copay / prescription (mail order) RX3 - 50% coinsurance / prescription (retail & mail order) RX6 - Not covered | | 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 . |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | 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. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| If you need immediate medical attention | Emergency room care | \$100 copay /visit | \$100 copay /visit | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | \$50 copay /visit | \$50 copay /visit | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$500 copay /per admission | Not covered | 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 | 20% coinsurance | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$50 copay /visit-office or freestanding facility 20% coinsurance -hospital | Not covered | None |
| | Inpatient services | \$500 copay /per admission | Not covered | 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 | \$30 copay (initial visit only), then no charge | Not covered | Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. |

| 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 professional services | 20% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | \$500 copay /per admission | Not covered | 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 | 20% coinsurance | 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 | \$50 copay /visit-office or freestanding facility 20% coinsurance -hospital | Not covered | 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 | 20% coinsurance | Not covered | 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 | 20% coinsurance | 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 | 20% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% up to \$10,000 of the total cost of the service. |
| If your child needs | Children's eye exam | No charge | Not covered | Coverage limited to one exam/year. |

| 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) | |
| dental or eye care | 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](#).)

| | | |
|--|---|---|
| <ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Child) | <ul style="list-style-type: none"> • Habilitation services • Long Term Care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • 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.)

| | | |
|---|---|--|
| <ul style="list-style-type: none"> • Acupuncture (in lieu of anesthesia) • Bariatric Surgery • Chiropractic Care | <ul style="list-style-type: none"> • Hearing Aids (Child) • Infertility Treatment | <ul style="list-style-type: none"> • 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, 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 | \$3,000 |
| ■ 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$13,211 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$1094 |
| Coinsurance | \$33 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,187 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---------|
| ■ The plan's overall deductible | \$3,000 |
| ■ 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,389 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles* | \$3,000 |
| Copayments | \$851 |
| Coinsurance | \$346 |
| What isn't covered | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$4,252 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---------|
| ■ The plan's overall deductible | \$3,000 |
| ■ 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,934 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles* | \$1,133 |
| Copayments | \$350 |
| Coinsurance | \$283 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,766 |