

PLAN T

NETWORK ONLY PLAN-EFF 1/1/16

BENEFIT SUMMARY

Affiliated Physicians & Employers Health Plan

A NJ Self-Insured MEWA

| Benefit/Feature No Referrals Required | In Network Providers QualCare Regional HMO network Cigna Open Access Plus (OAP) Network Providers & Facilities Online Search: www.apehp.com Call 1-888-670-8135 | Out-of-Network Providers |
|--|---|--------------------------|
| Deductible (Embedded*) (every Calendar year) | \$1,500/Individual; \$3,000/Family | N/A |
| Out-of-Pocket Maximum (Embedded*) (every Calendar Year) | \$4,000/Individual; \$8,000/Family | N/A |
| <i>(Out of Pocket Maximum includes deductible, coinsurance, medical copayments and prescription copays/coinsurance but does not include non covered amounts above the plan's fee schedule or allowable charge, or pre-authorization penalties.)</i> | | |
| Lifetime Maximum Benefit | Unlimited | N/A |
| PHYSICIAN SERVICES | | |
| Office Visit to PCP or Specialist | You pay \$30 PCP /\$60 Specialist copay/visit | Not Covered |
| Routine Gynecological Care | Plan pays 100% | Not Covered |
| Pre-Natal Care | You pay \$30 copay (initial visit only) | Not Covered |
| Routine Physical | Plan pays 100% | Not Covered |
| Well-Child Care | Plan pays 100% | Not Covered |
| Professional Services, Inpatient/Outpatient/ Office | Plan pays 70%, after deductible | Not Covered |
| HOSPITAL SERVICES | | |
| Inpatient Admission ⁽¹⁾ | Plan pays 70% after deductible | Not Covered |
| Outpatient Services | Plan pays 70% after deductible | Not Covered |
| Outpatient Ambulatory Surgery ⁽¹⁾ | | |
| - Physician Charges | Plan pays 70%, after deductible | Not Covered |
| - Hospital Charges | Plan pays 70%, after deductible | Not Covered |
| - Free-standing Surgical Center | Plan pays 70%, after deductible | Not Covered |
| Urgent Care Center | You pay \$60 copay/visit | Not Covered |
| Emergency Room Services | \$100 copay/visit (Copay waived if admitted) | |
| (Out-of-Area True Emergency Admissions are subject to In Network Benefits) | | |
| Inpatient Rehab & Skilled Nursing ⁽¹⁾ | Plan pays 70%, after deductible (60 days per incident maximum) | Not Covered |
| OTHER SERVICES | | |
| Outpatient Therapies ⁽¹⁾ Includes Physical, Occupational & Speech | All Therapies (60 visit combined limit, every plan year) | |
| - Hospital Based | Plan pays 70% after deductible | Not Covered |
| - Office Based or Freestanding Facility | You pay \$60 copay/visit | Not Covered |
| Laboratory Services ⁽²⁾ | | |
| - Hospital Based | Plan pays 70%, after deductible | Not Covered |
| - Office Based or Freestanding Facility | Plan pays 100% when administered in provider's office** Plan pays 70% after deductible for all lab services NOT available through Quest or Cigna OAP** | Not Covered |
| **Quest diagnostics is QualCare's Exclusive Lab Provider in New Jersey. Inside New Jersey, you must use Quest Diagnostics for all laboratory services. Labs not sent to Quest Diagnostics, when services are rendered inside New Jersey, will be subject to the Out-of-Network benefit, should coverage apply. When services are rendered outside of New Jersey, Cigna Open Access Plus (OAP) labs may be utilized. | | |
| Diagnostic Services ⁽¹⁾ | X-Rays, MRIs, CT Scans, PET Scans etc. | |
| - Hospital Based | Plan pays 70%, after deductible | Not Covered |
| - Office Based or Freestanding Facility | Plan pays 70%, after deductible | Not Covered |
| Home Health Care ⁽¹⁾ | Plan pays 70%, after deductible (60 visits per year/not to exceed 4 hrs per visit) | Not Covered |
| Chiropractic Care <small>Covered age 18 and older only</small> | You pay \$60 copay/visit (30 visit maximum every plan year) | Not Covered |
| Fertility Treatments/Services - refer to SPD section Medical Benefits, What's Covered beginning on page 17 for description of specific covered services | | |
| - Hospital based | Plan pays 70%, after deductible | Not Covered |
| - Freestanding | Plan pays 70%, after deductible | Not Covered |
| - Office based | Plan pays 70%, after deductible | Not Covered |
| MENTAL DISORDER & SUBSTANCE ABUSE SERVICES | | |
| Inpatient Mental Disorder/Substance Abuse ⁽¹⁾ | Plan pays 70%, after deductible | Not Covered |
| Outpatient Mental Disorder/Substance Abuse | | |
| - Hospital Based | Plan pays 70%, after deductible | Not Covered |
| - Office Based or Freestanding Facility | You pay \$60 copay/visit | Not Covered |
| <p>Note: There is No Out-of-Network benefit under PLAN T- NETWORK ONLY PLAN. If you choose to seek services outside of the network, you will be responsible for the full amount charged by the provider. For all Out-of-Network emergency hospital, physician and ancillary services the Plan will pay at the providers billed charges or a negotiated rate, whichever is less. Emergency Care and Urgent Care provided by an Out-of-Network Provider will be reimbursed at the network level, subject to the following: 1) The covered person must call the Plan at 1-888-670-8135 within 48 hours, or as soon as reasonably possible after an Emergency Care and Urgent Care visit. 2) Follow-up care or treatment by an Out-of-Network Provider will be treated as network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the covered person can continue care provided by Participating/Network Providers.</p> <p>(1) Some of these services require pre-authorization. For Network services, your physician should obtain pre-authorization for you, however, you are ultimately responsible for pre-authorization for all services (In-Network), otherwise a penalty of 50% of the Plan's allowable amount, to a maximum of \$10,000 will be applied. Refer to www.apehp.com for a complete pre-authorization list.</p> <p>(2) Laboratory services performed in an office setting must be sent to Quest Diagnostics for benefit to be covered 100%. Labs not sent to Quest Diagnostics will be subject to the Out-of-Network benefit or not covered at all if no Out-of-Network benefit is offered.</p> <p>Note: This summary is not intended to be a comprehensive list of services and is not a guarantee of coverage. Once enrolled, you will be supplied with a Plan Document/Summary Plan Description (SPD) that will detail all covered services.</p> <p>*Embedded means you can satisfy the Family "Deductible" or the Family "Maximum Out-of-pocket" by meeting the individual amount for any one (1) covered family Member and then any combination of family Members may satisfy the remaining amount. No more than the individual amount will be credited to the Family amount for any one Covered Person and no Covered Person will be required to meet more than the individual amount each Benefit Year.</p> | | |