PLAN K

NETWORK ONLY HIGH DEDUCTIBLE PLAN

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)	$2,000/Individual; $4,000/Family	N/A
Out-of-Pocket Maximum (Embedded*) (every Calendar Year)	$6,850/Individual; $13,700/Family	N/A
*(Out of Pocket Maximum **includes deductible, coinsurance and 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.)*		
Lifetime Maximum Benefit	Unlimited	N/A
PHYSICIAN SERVICES		
Office Visit to PCP/ Specialist	You pay $30 PCP/ $50 Spec. copay/visit, after deductible	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 100% after deductible	Not Covered
HOSPITAL SERVICES		
Inpatient Admission (1)	$500 per admission copay, after deductible	Not Covered
Outpatient Services	$200 Copay, after deductible	Not Covered
Outpatient Ambulatory Surgery (1)		
- Physician Charges	Plan pays 100% after deductible	Not Covered
- Hospital Charges	$200 Copay, after deductible	Not Covered
- Free-standing Surgical Center	Plan pays 100% after deductible	Not Covered
Urgent Care Center	You pay $50 copay/visit, after deductible	Not Covered
Emergency Room Services	$100 copay/visit, after deductible (Copay waived if admitted) **(Out-of-Area True Emergency Admissions are subject to In Network Benefits)**	
Inpatient Rehab & Skilled Nursing (1)	$500 per admission copay, 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	$200 Copay, after deductible	Not Covered
- Freestanding Facility or Physician Charges	Plan pays 100% after deductible	
- Office Based	You pay $50 copay/visit, after deductible	
Laboratory Services (2)		
- Hospital Based	$200 Copay, after deductible	Not Covered
- Office Based or Freestanding Facility	100% when administered in provider's office** Plan pay 100% 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 or Freestanding Facility	$200 Copay, after deductible	Not Covered
- Office Based	Plan pays 100% after deductible	Not Covered
Home Health Care (1)	Plan pays 100% after deductible **(60 visits per year/not to exceed 4 hrs per visit)**	Not Covered
Chiropractic Care Covered age 18 and older only	You pay $50 copay/visit, after deductible **(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 100% after deductible	Not Covered
- Freestanding	Plan pays 100% after deductible	
- Office based	Plan pays 100% after deductible	
MENTAL DISORDER & SUBSTANCE ABUSE SERVICES		
Inpatient Mental Disorder/Substance Abuse (1)	$500 per admission copay, after deductible	Not Covered
Outpatient Mental Disorder/Substance Abuse		
- Hospital Based or Freestanding Facility	$200 Copay, after deductible	Not Covered
- Physician Charges	Plan pays 100% after deductible	Not Covered
- Office Based	You pay $50 copay/visit, after deductible	Not Covered

Note: There is No Out-of-Network benefit under PLAN K- NETWORK ONLY HIGH DEDUCTIBLE 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.

(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.

(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.

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.

*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.

This is self-insured plan administered by:
QUALCARE INC

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