
 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.dol.gov/ebsa/healthreform](http://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 <a href="#">deductible</a> ?                                | In Network: \$3,000 person / \$6,000 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> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | 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> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> \$6,000 person / \$12,000 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.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <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> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.qualcareinc.com/FindADoctor/FindADoctor_QCGeneric.aspx">www.qualcareinc.com/FindADoctor/FindADoctor_QCGeneric.aspx</a> or call 1-888-670-8135 for a list of <a href="#">network providers</a> . For outside NJ, <a href="http://www.sarhcpdir.cigna.com/mcoap">www.sarhcpdir.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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | 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<br>(You will pay the least) | Out-of-Network Provider<br>(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       | \$30 <a href="#">copay</a> /office visit     | Not covered  | None  |
|  | <a href="#">Specialist</a> visit                       | \$50 <a href="#">copay</a> /visit            | Not covered  | 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>              | Not covered  | None  |
|  | Imaging (CT/PET scans, MRIs)                           | 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 <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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |   |
| <p><b>If you need drugs to treat your illness or condition</b><br/>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a> and <a href="http://www.apehp.com/forms-documents">www.apehp.com/forms-documents</a></p> | Generic drugs             | <b>RX1</b> - \$6 <a href="#">copay</a> / prescription (retail),<br>\$15 <a href="#">copay</a> / prescription (mail order)<br><b>RX2</b> - \$20 <a href="#">copay</a> / prescription (retail),<br>\$50 <a href="#">copay</a> / prescription (mail order)<br><b>RX3</b> - \$15 <a href="#">copay</a> / prescription (retail),<br>\$37.50 <a href="#">copay</a> / prescription (mail order)<br><b>RX6</b> - 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     | <b>RX1</b> - \$25 <a href="#">copay</a> / prescription (retail),<br>\$62.50 <a href="#">copay</a> / prescription (mail order)<br><b>RX2</b> - \$40 <a href="#">copay</a> / prescription (retail),<br>\$100 <a href="#">copay</a> / prescription (mail order)<br><b>RX3</b> - 50% <a href="#">coinsurance</a> / prescription (retail & mail order)<br><b>RX6</b> - 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.<br><br><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 | <b>RX1</b> - \$40 <a href="#">copay</a> / prescription (retail),<br>\$100 <a href="#">copay</a> / prescription (mail order)<br><b>RX2</b> - \$70 <a href="#">copay</a> / prescription (retail),<br>\$175 <a href="#">copay</a> / prescription (mail order)<br><b>RX3</b> - 50% <a href="#">coinsurance</a> / prescription (retail & mail order)<br><b>RX6</b> - 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.<br><br><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> . |

| Common Medical Event                           | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|--|---|--|---|
|  |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
|  | <a href="#">Specialty drugs</a>                  | <b>RX1</b> - \$25-\$40 <a href="#">copay</a> / prescription (retail),<br>\$62.50-\$100 <a href="#">copay</a> / prescription (mail order)<br><b>RX2</b> - \$40-\$70 <a href="#">copay</a> / prescription (retail),<br>\$100-\$175 <a href="#">copay</a> / prescription (mail order)<br><b>RX3</b> - 50% <a href="#">coinsurance</a> / prescription (retail & mail order)<br><b>RX6</b> - 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.<br><br><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> . |
| <b>If you have outpatient surgery</b>          | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>   | Not covered  | <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.   |
|  | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | Not covered  |   |
| <b>If you need immediate medical attention</b> | <a href="#">Emergency room care</a>              | \$100 <a href="#">copay</a> /visit  | \$100 <a href="#">copay</a> /visit                 | 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  |
| <b>If you have a hospital stay</b>             | Facility fee (e.g., hospital room)               | \$500 <a href="#">copay</a> /per admission  | 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 <a href="#">allowed amount</a> of the service.   |
|  | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | Not covered  |   |

| Common Medical Event   | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$50 <a href="#">copay</a> /visit-office or freestanding facility 20% <a href="#">coinsurance</a> -hospital    | Not covered  | None   |
|  | Inpatient services                        | \$500 <a href="#">copay</a> /per admission   | 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 <a href="#">allowed amount</a> of the service.  |
| <b>If you are pregnant</b>   | Office visits                             | \$30 <a href="#">copay</a> (initial visit only), then no charge  | Not covered  | <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>  | Not covered  | None   |
|  | Childbirth/delivery facility services     | \$500 <a href="#">copay</a> /per admission   | 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 <a href="#">allowed amount</a> of the service.  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>  | Not covered  | 60 visits/year<br><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 or freestanding facility<br>20% <a href="#">coinsurance</a> -hospital | Not covered  | 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>  | Not covered  | 60 visits/incident<br><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>  |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|---|
|   |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
|   |   |  |  | 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.   |
| <b>If your child needs dental or eye care</b> | 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](#).)**

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

**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](#) \$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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$13,211</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

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

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,389</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

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

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,934</b> |
|---------------------------|----------------|

**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> |