

# 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: <a href="http://www.apehp.com">www.apehp.com</a> Call 1-888-670-8135	Out-of-Network Providers
<b>Deductible (Embedded*)</b> (every Calendar year)	\$1,500/Individual; \$3,000/Family	N/A
<b>Out-of-Pocket Maximum (Embedded*)</b> (every Calendar Year) <small>(Out of Pocket Maximum <u>includes deductible, coinsurance, medical copayments and prescription copays/coinsurance</u> but does not include non covered amounts above the plan's fee schedule or allowable charge, or pre-authorization penalties.)</small>	\$4,000/Individual; \$8,000/Family	N/A
<b>Lifetime Maximum Benefit</b>	Unlimited	N/A
<b>PHYSICIAN SERVICES</b>		
<b>Office Visit to PCP or Specialist</b>	You pay \$30 PCP /\$60 Specialist copay/visit	Not Covered
<b>Routine Gynecological Care</b>	Plan pays 100%	Not Covered
<b>Pre-Natal Care</b>	You pay \$30 copay (initial visit only)	Not Covered
<b>Routine Physical</b>	Plan pays 100%	Not Covered
<b>Well-Child Care</b>	Plan pays 100%	Not Covered
<b>Professional Services, Inpatient/Outpatient/ Office</b>	Plan pays 70%, after deductible	Not Covered
<b>HOSPITAL SERVICES</b>		
<b>Inpatient Admission</b> <sup>(1)</sup>	Plan pays 70% after deductible	Not Covered
<b>Outpatient Services</b>	Plan pays 70% after deductible	Not Covered
<b>Outpatient Ambulatory Surgery</b> <sup>(1)</sup> - Physician Charges - Hospital Charges - Free-standing Surgical Center	Plan pays 70%, after deductible Plan pays 70%, after deductible Plan pays 70%, after deductible	Not Covered Not Covered Not Covered
<b>Urgent Care Center</b>	You pay \$60 copay/visit	Not Covered
<b>Emergency Room Services</b>	\$100 copay/visit (Copay waived if admitted) <b>(Out-of-Area True Emergency Admissions are subject to In Network Benefits)</b>	
<b>Inpatient Rehab &amp; Skilled Nursing</b> <sup>(1)</sup>	Plan pays 70%, after deductible <b>(60 days per incident maximum)</b>	Not Covered
<b>OTHER SERVICES</b>		
<b>Outpatient Therapies</b> <sup>(1)</sup> Includes Physical, Occupational & Speech - Hospital Based - Office Based or Freestanding Facility	<b>All Therapies (60 visit combined limit, every plan year)</b> Plan pays 70% after deductible You pay \$60 copay/visit	Not Covered Not Covered
<b>Laboratory Services</b> <sup>(2)</sup> - Hospital Based  - Office Based or Freestanding Facility	Plan pays 70%, after deductible  Plan pays 100% when administered in provider's office** Plan pays 70% after deductible for all lab services <b>NOT</b> available through Quest or Cigna OAP**	Not Covered  Not Covered
<b>**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.</b>		
<b>Diagnostic Services</b> <sup>(1)</sup> - Hospital Based - Office Based or Freestanding Facility	<b>X-Rays, MRIs, CT Scans, PET Scans etc.</b> Plan pays 70%, after deductible Plan pays 70%, after deductible	Not Covered Not Covered
<b>Home Health Care</b> <sup>(1)</sup>	Plan pays 70%, after deductible <b>(60 visits per year/not to exceed 4 hrs per visit)</b>	Not Covered
<b>Chiropractic Care</b> <small>Covered age 18 and older only</small>	You pay \$60 copay/visit <b>(30 visit maximum every plan year)</b>	Not Covered
<b>Fertility Treatments/Services</b> - refer to SPD section Summary of Covered Services and Supplies on page 28 for description of specific covered services - Hospital based - Freestanding - Office based	Plan pays 70%, after deductible Plan pays 70%, after deductible Plan pays 70%, after deductible	Not Covered
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES</b>		
<b>Inpatient Mental Health/Substance Use Disorder</b> <sup>(1)</sup>	Plan pays 70%, after deductible	Not Covered
<b>Outpatient Mental Health/Substance Use Disorder</b> - Hospital Based - Office Based or Freestanding Facility	Plan pays 70%, after deductible You pay \$60 copay/visit	Not Covered Not Covered
<b>Note:</b> There is <b>No Out-of-Network</b> benefit under <b>PLAN T- NETWORK ONLY PLAN</b> . 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.		
<b>(1)</b> 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 <a href="http://www.apehp.com">www.apehp.com</a> for a complete pre-authorization list.		
<b>(2)</b> 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.		
<b>Note:</b> 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.		
<b>*Embedded</b> 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:

