

# PLAN B

## OPEN ACCESS POS NETWORK PLAN BENEFIT SUMMARY

Benefit/Feature	In Network Providers QualCare Regional Open Access POS 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>No Referrals Required</b>		
<b>Deductible (Embedded*)</b> (every Calendar year)	\$500/Individual; \$1,000/Family	\$1,500/Individual; \$3,000/Family
<b>Out-of-Pocket Maximum (Embedded*)</b> (every Calendar Year) <i>(Out of Pocket Maximum is combined between In-Network and Out-of-Network and 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>	(Combined In/Out) \$6,850/Individual; \$13,700/Family	
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited
<b>PHYSICIAN SERVICES</b>		
<b>Office Visit to PCP/ Specialist</b>	You pay \$30 PCP/ \$50 Spec. copay/visit	Plan pays 70% <sup>(1)</sup> after deductible
<b>Routine Gynecological Care</b>	Plan pays 100%	Not Covered
<b>Pre-Natal Care</b>	You pay \$30 copay/initial visit only	Plan pays 70% <sup>(1)</sup> after deductible
<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 90% after deductible	Plan pays 70% <sup>(1)</sup> after deductible
<b>HOSPITAL SERVICES</b>		
<b>Inpatient Admission</b> <sup>(2)</sup>	Plan pays 90% after deductible	Plan pays 70% <sup>(1)</sup> after deductible
<b>Outpatient Services</b>	Plan pays 90% after deductible	Plan pays 70% <sup>(1)</sup> after deductible
<b>Outpatient Ambulatory Surgery</b> <sup>(2)</sup> - Physician Charges - Hospital Charges - Free-standing Surgical Center	Plan pays 90% after deductible Plan pays 90% after deductible Plan pays 90% after deductible	Plan pays 70% <sup>(1)</sup> after deductible Plan pays 70% <sup>(1)</sup> after deductible Plan pays 70% <sup>(1)</sup> after deductible up to a maximum allowable of \$1,000 per surgery
<b>Urgent Care Center</b>	You pay \$50 copay/visit	You pay \$50 copay/visit
<b>Emergency Room Services</b>	You pay \$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>(2)</sup>	Plan pays 90% after deductible <b>(60 days per incident maximum)</b>	Plan pays 70% <sup>(1)</sup> after deductible
<b>OTHER SERVICES</b>		
<b>Outpatient Therapies</b> <sup>(2)</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 90% after deductible You pay \$50 copay/visit	
<b>Laboratory Services</b> <sup>(3)</sup> - Hospital Based - Office Based or Freestanding Facility	Plan pays 90% after deductible 100% when administered in provider's office** Plan pays 90% after deductible for all lab services <b>NOT</b> available through Quest or Cigna OAP**	Plan pays 70% <sup>(1)</sup> after deductible Plan pays 70% <sup>(1)</sup> after deductible
<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>(2)</sup> - Hospital Based - Office Based or Freestanding Facility	<b>X-Rays, MRIs, CT Scans, PET Scans etc.</b> Plan pays 90% after deductible Plan pays 90% after deductible	Plan pays 70% <sup>(1)</sup> after deductible Plan pays 70% <sup>(1)</sup> after deductible
<b>Durable Medical Equipment</b> <sup>(2)</sup>	Plan pays 90% after deductible	Not Covered
<b>Home Health Care</b> <sup>(2)</sup>	Plan pays 90% 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 \$50 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 90% after deductible Plan pays 90% after deductible Plan pays 90% after deductible	Plan pays 70% <sup>(1)</sup> after deductible Plan pays 70% <sup>(1)</sup> after deductible up to a maximum allowable of \$1,000 per surgery Plan pays 70% <sup>(1)</sup> after deductible
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES</b>		
<b>Inpatient Mental Health/Substance Use Disorder</b> <sup>(2)</sup>	Plan pays 90% after deductible	Plan pays 70% <sup>(1)</sup> after deductible
<b>Outpatient Mental Health/Substance Use Disorder</b> - Hospital based - Freestanding - Physician Charges - Office based	Plan pays 90% after deductible Plan pays 90% after deductible Plan pays 90% after deductible You pay \$30 copay/visit	Plan pays 70% <sup>(1)</sup> after deductible Plan pays 70% <sup>(1)</sup> after deductible Plan pays 70% <sup>(1)</sup> after deductible Plan pays 70% <sup>(1)</sup> after deductible
<b>(1) For all Out-of-Network elective and non-emergent services the Plan will not pay more than Plan's Allowable Charges which will be based on 140% of current year Medicare/RBRVS.</b>		
<b>(2) 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 or out-of-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>		
<b>(3) 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>		
<b>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.</b>		
<small>*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.</small>		