**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Affiliated Physicians & Employers Health Plan D: QualCare**

**Coverage Period:** 04/01/2013 – 03/31/2014

**Coverage for:** Individual/Family | **Plan Type:** PPO

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### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In Network: $0  Out of Network: $2,500 person/ $5,000 family</td>
<td>You must pay all Out of Network costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services. The deductible plan year is January 1 – December 31. See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. $2,500 person/ $5,000 Family In Network for hospital based services</td>
<td>You must pay all of the costs for these services up to the specific <strong>deductible</strong> amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>No. In Network  Yes. Out of Network, $6,000 person/ $12,000 family</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Deductible, copays for medical/Rx, non covered amounts above the plan’s fee schedule or allowable charge, or pre-authorization penalties</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. QualCare PPO Network. See <a href="http://qualcareinc.com/qcmewa">qualcareinc.com/qcmewa</a> or call 1-888-670-8135; Outside NJ <a href="http://www.firsthealth.com">www.firsthealth.com</a>, or call 1-888-685-7774.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn’t cover?</strong></td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 4. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

---

**Questions:** Call 1-888-670-8135 or visit us at [www.qualcareinc.com/qcmewa](http://www.qualcareinc.com/qcmewa)

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#### What this Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**. Out of Network reimbursement to all providers is based on the Plan’s fee schedule (allowed amount). Any Out of Network providers can balance bill the patient for any amounts in excess of the Plan’s fee schedule. This excess amount is considered a non-covered amount and does not accrue towards the Out of Pocket maximum.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

#### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$15 copay</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$15 copay</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>$2500 deductible if hospital based.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>$2500 deductible if hospital based.</td>
</tr>
</tbody>
</table>

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**Coverage for:** Individual/Family | **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td></td>
<td></td>
<td>All RX plans cover 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. Call Express Scripts for questions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RX1 - $6/$15; RX2 - $20/$50; RX3 - $15/$37.50; RX4 - ded,$6/ ded,$15; RX5 - ded,$15/ ded,$37.50; RX6 - Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td></td>
<td></td>
<td>RX 3 &amp; 5 - Minimum member pays for retail is $25; maximum $500. Mail order min $62.50; max $1,250. 30-day supply (retail); 90-day supply (mail); Retail Refill Allowance, Step Therapy or Dispense as Written may apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RX1 - $25/$62.50; RX2 - $40/$100; RX3 - 50%/50%; RX4 - ded,$25/ ded,$62.50; RX5 - ded,50%/50%; RX6 - Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td></td>
<td></td>
<td>RX 3 &amp; 5 - Minimum member pays for retail is $25; maximum $500. Mail order min $62.50; max $1,250. 30-day supply (retail); 90-day supply (mail); Retail Refill Allowance, Step Therapy or Dispense as Written may apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RX1 - 40/$100; RX2 - $70/$175; RX3 - 50%/50%; RX4 ded,$40/ $100; RX5 - ded,50%/50%; RX6 - Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Need authorization</td>
<td></td>
<td>Subject to review must contact Express Scripts.</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>$1,000 maximum allowable per surgery at Freestanding Out of Network;</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$50 copay</td>
<td>$50 Copay</td>
<td>Non-emergency not covered.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Non-emergency not covered.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15 copay</td>
<td>30% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$2,500</td>
<td>30% coinsurance</td>
<td>Services require pre-authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$15 copay at office/freestanding</td>
<td>30% coinsurance</td>
<td>$2,500 deductible if hospital based.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$2,500</td>
<td>30% coinsurance</td>
<td>Services require pre-authorization.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$15 copay at office/freestanding</td>
<td>30% coinsurance</td>
<td>$2,500 deductible if hospital based.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$2,500</td>
<td>30% coinsurance</td>
<td>Services require pre-authorization.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$15 copay</td>
<td>30% coinsurance</td>
<td>Copay applies to initial visit only.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$2,500</td>
<td>30% coinsurance</td>
<td>Services require pre-authorization.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs (all services in this section require pre-authorization)</td>
<td>Home health care</td>
<td>No Charge</td>
<td>Not Covered</td>
<td><strong>In-Network</strong> max 60 visits per year/not exceed 4 hours per visit/ <strong>Out of Network</strong> – Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15 copay at office/freestanding</td>
<td>30% coinsurance</td>
<td>60 days per condition maximum; $2,500 deductible if hospital based.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15 copay at office/freestanding</td>
<td>30% coinsurance</td>
<td>Physical, Occupational &amp; Speech therapies, 60 visits combined max every plan year; $2,500 deductible if hospital based.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>60 days per condition maximum; Services require pre-authorization. $2,500 deductible applies.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Services require pre-authorization.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>Services require pre-authorization.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$15 copay</td>
<td>Not Covered</td>
<td>Limited to one exam per year.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

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### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

#### Affiliated Physicians & Employers Health Plan D: QualCare

**Coverage Period:** 04/01/2013 – 03/31/2014

**Coverage for:** Individual/Family  
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#### What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental check-up</td>
<td></td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>May be provided under a separate benefit package.</td>
</tr>
</tbody>
</table>

#### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Infertility treatment
- Hearing aids
- Foot Orthotics
- Non-emergency care when traveling outside the U.S.
- Exercise Program
- Routine foot care

**Other Covered Services** (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (when deemed medically necessary to substitute forms of anesthesia or pain management)
- Chiropractic care (In Network only)
- Gastric Bypass or Lap Band Surgery (when medically necessary for morbid obesity)

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Your Rights to Continue Coverage:

** Individual health insurance sample –
Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-670-8135. You may also contact your state insurance department at 1-800-446-7467 State Department of Insurance.

** Group health coverage sample –
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebia, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cheio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Customer Service at (888) 670-8135.

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,025
- **Patient pays:** $2,515

#### Sample care costs:

<table>
<thead>
<tr>
<th>Hospital charges (mother)</th>
<th>$2,700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>$2,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays</td>
<td>$15</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,515</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,090
- **Patient pays:** $310

#### Sample care costs:

<table>
<thead>
<tr>
<th>Prescriptions</th>
<th>$2,900</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays</td>
<td>$310</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$310</strong></td>
</tr>
</tbody>
</table>

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-888-670-8135.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- **No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-888-670-8135 or visit us at www.qualcareinc.com/qcmewa
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.qualcareinc.com/MEWA/products_mewa_health_plans_APEHP.aspx or call 1-888-670-8135 to request a copy.