Raritan Bay Medical Center PPO Plan

Coverage Period: 01/01/2016 – 12/31/2016

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

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://intranetportal/depts/hr/DocumentLibrary/Forms/AllItems.aspx or by calling 1-732-324-6000.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Inner Circle: None In –Network: **$850** person **/ $1,700** family. Out-of Network: **$1,500** person **/ $3,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Inner Circle: **$1,000** person / **$2,000** family. In -Network **$5,600** person **/ $11,200** family (Total OPP will not to exceed $6,600 person/$13,200 family including medical & prescription expenses for Inner Circle and In Network) Out-of Network **$8,000** person **/ $16,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for **specific** covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of QualCare participating providers go to www.qualcareinc.com or call 1-800-992-6613 for additional network providers	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see	No. You don't need a referral to see a	You can see the **specialist** you choose without permission from this plan.

a specialist?	specialist.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

- **Co-payments** are fixed dollar amounts (for example, $30) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- 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 encourages you to use inner circle **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Inner Circle Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	$40 copay/visit	40% coinsurance	————————none————————
	Specialist visit	$40 copay/visit	$50 copay/visit	40% coinsurance	————————none————————
	Other practitioner office visit	Chiropractor: $40 co-pay /visit	Chiropractor: 75% coinsurance	Chiropractor: 40% coinsurance/visit	30 visits max per year.
	Preventive care/ screening / immunization	No charge	No charge	40% coinsurance	If you receive services in addition to an office visit, additional copayments, deductibles or coinsurance may apply
If you have a test	Diagnostic test (x-ray, blood work)	No charge	25% coinsurance	40% coinsurance	Inner Circle Physician charges are 10% coinsurance
	Imaging (CT/PET scans, MRIs)	No charge	25% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Inner Circle Provider	In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or by calling 888-202-1654	Generic drugs	Not covered	Retail: $10 copay Mail: $25 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (at CVS Retail Pharmacy or via mail order prescription)
	Single-source brand drugs	Not covered	Retail: $45 copay Mail: $112.50 copay	Not covered	
	Multi-source brand drugs	Not covered	Retail: $65 copay Mail: $162.50 copay	Not covered	
	Specialty drugs	Not covered	Retail & Mail: 50% Coinsurance	Not covered	Some specialty drugs may not be available at a retail pharmacy. Retail: $150 Min, $450 Max Mail: $150 Min, $450 Max (1-34 day supply), $375 Min, $1,125 Max (35-90 day supply)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	25% coinsurance	Not covered	Your costs may be less if performed in an outpatient hospital setting.
	Physician/surgeon fees	10% coinsurance	25% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	No charge	No charge	No charge	Copayment, coinsurance, and deductible for non-emergent use of emergency room services may apply
	Emergency medical transportation	10% coinsurance	25% coinsurance	40% coinsurance	——————none——————
	Urgent care	Not covered	Not covered	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	25% coinsurance	40% coinsurance	Precertification is required

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Inner Circle Provider	In-Network Provider	Out-of-Network Provider	
	Physician/surgeon fee	No charge	25% coinsurance	40% coinsurance	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	$50copay/admission	40% coinsurance	————————none————————
	Mental/Behavioral health inpatient services-facility	No charge	25% coinsurance	40% coinsurance	Precertification is required
	Substance use disorder outpatient services	No charge	$50copay/admission	40% coinsurance	————————none————————
	Substance use disorder inpatient services-facility	No charge	25% coinsurance	40% coinsurance	Precertification is required
If you are pregnant	Prenatal and postnatal care	$30 copay	$40 copay	40% coinsurance	If you receive services in addition to an office visit, additional copayments, deductibles or coinsurance may apply. For in-network providers, copay applies to initial visit only.
	Delivery and all inpatient services	No charge	25% coinsurance	40% coinsurance	Precertification is required
If you need help recovering or have other special health needs	Home health care	10% coinsurance	25% coinsurance	Not covered	Precertification required. 60 visit per year maximum.
	Rehabilitation services	10% coinsurance	25% coinsurance	40% coinsurance	Precertification is required. Visit limits may apply for rehabilitation services.
	Habilitation services	10% coinsurance	25% coinsurance	40% coinsurance	Precertification is required. Visit limits may apply for habilitation services
	Skilled nursing care	Not covered	20% coinsurance	40% coinsurance	Precertification required. 60 days maximum per calendar year
	Durable medical equipment	10% coinsurance	25% coinsurance	40% coinsurance	Precertification required
	Hospice service	Not covered	25% coinsurance	40% coinsurance	Precertification required

Common Medical Event	Services You May Need	Your cost if you use a Inner Circle Provider	In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$30 copay	$40 copay	Not covered	Limited to one routine exam per year
	Glasses	Not Available	Not Available	Covered for Reimbursement Only	Reimbursed up to $50, once every 24 months
	Dental check-up	Not covered	Not covered	Not covered	May be provided under a separate benefit plan offering

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
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine foot care
- Non-emergency care when traveling outside the U.S.

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
- Bariatric surgery
- Chiropractic care (chiropractic care for eligible individuals age 18 or older)
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs – provided through the Healthy Lifestyle Program

Your Rights to Continue Coverage:

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 1-800-307-0230. 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/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.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:
Medical: QualCare, Inc. at 1-800-992-6613
Prescription: CVS/Caremark at 1-888-202-1654
Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
New Jersey Department of Banking and Insurance at 1-800-446-7467 or www.state.nj.us/dobi/consumer.

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

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** $5,210
- **Patient pays** $2,330

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$850
Co-pays	$60
Co-insurance	$1,270
Limits or exclusions	$150
Total	**$2,330**

These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-992-6613.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,500
- **Patient pays** $1,900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$850
Co-pays	$700
Co-insurance	$270
Limits or exclusions	$80
Total	**$1,900**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.