

PLAN M: COMMUNITY CARE HEALTH PLAN - NETWORK ONLY (GOLD)

COMMUNITY CARE NETWORK PLAN

BENEFIT SUMMARY

Benefit/Feature		Tier 1	Tier 2
No Referrals Required	Pre-authorization or Authorization Requirements	COMMUNITY CARE NETWORK (CCN) Providers & Facilities Online Search: www.apehp.com Call 1-888-670-8135	QUALCARE REGIONAL HMO NETWORK (Cigna Open Access Plus (OAP) Network for Out of Area Care- Outside of NJ)
Deductible (Embedded*) (every Calendar year)		None	\$2,500/Individual; \$5,000/Family
Out-of-Pocket Maximum (Embedded*) (every Calendar Year)		\$3,000/Individual; \$6,000/Family	\$6,000/Individual; \$12,000/Family
<i>(Out of Pocket Maximums are cumulative between Tier 1 and Tier 2 and includes deductible, coinsurance, medical copayments and prescription copay/coinsurance, but does not include non covered amounts above the plan's fee schedule or Plan's Allowable Charges, or pre-authorization penalties.)</i>			
Lifetime Maximum Benefit		Unlimited	Unlimited
PHYSICIAN SERVICES			
Office Visit to Primary Care Physician (PCP)		First 2 Visit ⁽³⁾ Covered 100%. Subsequent visits, You pay \$25 copay/visit You pay \$50 copay/visit	Plan pays 70% after deductible
Office Visit to Specialist		You pay \$50 copay/visit	Plan pays 70% after deductible
Gynecological Care (non-routine)		You pay \$50 copay/visit	Plan pays 70% after deductible
Preventive Services		Plan pays 100%	Plan pays 100%
Inpatient/Outpatient/Office Professional Services	Pre-authorization Required Inpatient & Outpatient	Plan pays 100%	Plan pays 70% after deductible
HOSPITAL SERVICES			
Inpatient Admission ⁽¹⁾	Pre-authorization Required	Plan pays 100% after \$500 per admission	Plan pays 70% after deductible
Outpatient Services	Pre-authorization Required	Plan pays 100% after \$50 copay	Plan pays 70% after deductible
Outpatient Ambulatory Surgery ⁽¹⁾ - Physician Charges - Hospital Charges - Free-standing Surgical Center	Pre-authorization Required	Plan pays 100% Plan pays 100% after \$50 copay Plan pays 100% after \$250 copay	Plan pays 70% after deductible Plan pays 70% after deductible Plan pays 70% after deductible
Urgent Care Center		You pay \$50 copay/visit	You pay \$50 copay/visit
Emergency Room Services	Authorization required within 48 hours	You pay \$100 copay/visit (Copoly waived if admitted)	You pay \$100 copay/visit (Copoly waived if admitted)
(Emergency services outside of the COMMUNITY CARE NETWORK (CCN) and Services Not Available within the COMMUNITY CARE NETWORK (CCN) will be paid at the Tier 1 Benefit Level)			
Inpatient Rehab & Skilled Nursing ⁽¹⁾ Includes cognitive therapy	Pre-authorization Required	Plan pays 100%, after \$500 admission copay (60 days per incident maximum)	Plan pays 70% after deductible
OTHER SERVICES			
Outpatient Therapies ⁽¹⁾ Includes Physical, Occupational & Speech	Pre-authorization Required	You pay \$50 copay/visit All Therapies (60 visit combined limit, every plan year)	Plan pays 70% after deductible
Laboratory Services ⁽²⁾ - Inpatient - Outpatient Laboratory in CCN Only - Office Based or Freestanding Facility	N/A	Plan pays 100% at CCN Only Plan pays 100% at CCN Only 100% when administered in provider's office** Plan pays 100% for all lab services NOT available through Quest or Cigna OAP**	Plan pays 70% after deductible Plan pays 70% after deductible Plan pays 70% after deductible
**Quest Diagnostics is QualCare's Exclusive Lab Provider for COMMUNITY CARE NETWORK (CCN) and QualCare 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, and Labs not sent to Tier 2 providers will not be covered. When services are rendered outside of New Jersey, Cigna Open Access Plus (OAP) labs may be utilized.			
Diagnostic Services ⁽¹⁾ X-Rays, MRIs, CT Scans, PET Scans etc		Plan pays 100%	Plan pays 70% after deductible
Durable Medical Equipment ⁽¹⁾	Pre-authorization Required	Plan pays 100%	Plan pays 70% after deductible
Home Health Care ⁽¹⁾	Pre-authorization Required	You pay \$50 copay/visit (60 visits per year/not to exceed 4 hrs per visit)	Plan pays 70% after deductible
Chiropractic Care Covered age 18 and older only		You pay \$50 copay/visit (30 visit maximum every plan year)	You pay \$50 copay/visit
Fertility Treatments/Services - refer to SPD section Medical Benefits, What's Covered beginning on page 17 for description of specific covered services - Hospital based - Freestanding - Office based	Pre-authorization Required	Plan pays 100% after \$50 copay Plan pays 100% after \$250 copay Plan pays 100%	Plan pays 70% after deductible Plan pays 70% after deductible Plan pays 70% after deductible
MENTAL DISORDER & SUBSTANCE ABUSE SERVICES			
Inpatient Mental Disorder/Substance Abuse ⁽¹⁾	Pre-authorization Required	Plan pays 100%, after \$500 per admission	Plan pays 70% after deductible
Outpatient Mental Disorder/Substance Abuse		You pay \$50 copay/visit	Plan pays 70% after deductible
<p>Note: There is No Out-of-Network benefit under PLAN M: COMMUNITY CARE HEALTH PLAN - NETWORK ONLY (GOLD), except for emergency and urgent care, which will be reimbursed at the network level. If you choose to seek services outside of Tier 1 or Tier 2, 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.</p> <p>(1) Some of these services may require pre-authorization. Network providers should obtain pre-authorization for you. However, you are ultimately responsible for pre-authorization for all services by In-Network Providers. A penalty of 50% of the Plan's Allowable Charges, to a maximum of \$10,000 will be applied if pre-authorization is not obtained. Refer to www.apehp.com for a complete pre-authorization list.</p> <p>(2) In NJ, 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.</p> <p>(3) Preventive office visits do not count toward the first 2 Office Visits covered at 100%.</p> <p>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</p> <p>*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.</p>			