

# PLAN Y: COMMUNITY CARE HEALTH PLAN - NJ NETWORK ONLY (BRONZE)

## COMMUNITY CARE NETWORK PLAN

### BENEFIT SUMMARY

Benefit/Feature		Tier 1	Tier 2
<b>No Referrals Required</b>	<b>Pre-authorization or Authorization Requirements</b>	<b>COMMUNITY CARE NETWORK (CCN) Providers &amp; Facilities Online Search: <a href="http://www.apehp.com">www.apehp.com</a> Call 1-888-670-8135</b>	<b>QUALCARE REGIONAL HMO NETWORK No access to Cigna OAP under this plan</b>
<b>Deductible (Embedded*)</b> (every Calendar year)		\$3,000/Individual; \$6,000/Family (cumulative between Tier 1 and Tier 2)	\$6,000/Individual; \$12,000/Family (cumulative between Tier 1 and Tier 2)
<b>Out-of-Pocket Maximum (Embedded*)</b> (every Calendar Year)		\$6,850/Individual; \$13,700/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>			
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited
<b>PHYSICIAN SERVICES</b>			
<b>Office Visit to Primary Care Physician (PCP)</b>		First 2 Visits <sup>(3)</sup> Covered 100%. Subsequent visits, You pay \$30 copay/visit after deductible	Plan pays 50% after deductible
<b>Office Visit to Specialist</b>		You pay \$50 copay/visit after deductible	Plan pays 50% after deductible
<b>Routine Gynecological Care</b>		Plan pays 100%	Plan pays 100%
<b>Preventive Services</b>		Plan pays 100%	Plan pays 100%
<b>Inpatient/Outpatient/Office Professional Services</b>	<b>Pre-authorization Required Inpatient &amp; Outpatient</b>	Plan pays 50% after deductible	Plan pays 50% after deductible
<b>HOSPITAL SERVICES</b>			
<b>Inpatient Admission</b> <sup>(1)</sup>	<b>Pre-authorization Required</b>	\$500 per day copay up to \$2,500 maximum per admit	Plan pays 50% after deductible
<b>Outpatient Services</b>	<b>Pre-authorization Required</b>	Plan pays 50% after \$50 copay after deductible	Plan pays 50% after deductible
<b>Outpatient Ambulatory Surgery</b> <sup>(1)</sup> - Physician Charges - Hospital Charges - Free-standing Surgical Center	<b>Pre-authorization Required</b>	Plan pays 50% after deductible Plan pays 50% after \$50 copay after deductible Plan pays 50% after \$250 copay after deductible	Plan pays 50% after deductible Plan pays 50% after deductible Plan pays 50% after deductible
<b>Urgent Care Center</b>		You pay \$50 copay/visit	Plan pays 50% after deductible
<b>Emergency Room Services</b>	<b>Authorization required within 48 hours</b>	You pay \$100 copay/visit, then subject to the deductible (Copay waived if admitted) <b>(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)</b>	You pay \$100 copay/visit, then subject to the deductible (Copay waived if admitted)
<b>Inpatient Rehab &amp; Skilled Nursing</b> <sup>(1)</sup> Includes cognitive therapy	<b>Pre-authorization Required</b>	\$500 per day copay up to \$2,500 maximum per admit <b>(60 days per incident maximum)</b>	Plan pays 50% after deductible
<b>OTHER SERVICES</b>			
<b>Outpatient Therapies</b> <sup>(1)</sup> Includes Physical, Occupational & Speech	<b>Pre-authorization Required</b>	You pay \$50 copay/visit after deductible <b>All Therapies (60 visit combined limit, every plan year)</b>	Plan pays 50% after deductible
<b>Laboratory Services</b> <sup>(2)</sup> - Inpatient - Outpatient Laboratory in CCN Only  - Office Based or Freestanding Facility	<b>N/A</b>	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 <b>NOT</b> available through Quest	Plan pays 50% after deductible Plan pays 50% after deductible  Plan pays 50% after deductible
<i>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.</i>			
<b>Diagnostic Services</b> <sup>(1)</sup> X-Rays, MRIs, CT Scans, PET Scans etc		Plan pays 50% after deductible	Plan pays 50% after deductible
<b>Durable Medical Equipment</b> <sup>(1)</sup>	<b>Pre-authorization Required</b>	Plan pays 50% after deductible	Plan pays 50% after deductible
<b>Home Health Care</b> <sup>(1)</sup>	<b>Pre-authorization Required</b>	You pay \$50 copay/visit after deductible <b>(60 visits per year/not to exceed 4 hrs per visit)</b>	Plan pays 50% after deductible
<b>Chiropractic Care</b> Covered age 18 and older only		You pay \$50 copay/visit after deductible <b>(30 visit maximum every plan year)</b>	Plan pays 50% after deductible
<b>Fertility Treatments/Services</b> - refer to SPD section Medical Benefits, What's Covered beginning on page 17 for description of specific covered services - Hospital based - Freestanding - Office based	<b>Pre-authorization Required</b>	Plan pays 50% after \$50 copay after deductible Plan pays 50% after \$250 copay after deductible Plan pays 50% after deductible	Plan pays 50% after deductible Plan pays 50% after deductible Plan pays 50% after deductible
<b>MENTAL DISORDER &amp; SUBSTANCE ABUSE SERVICES</b>			
<b>Inpatient Mental Disorder/Substance Abuse</b> <sup>(1)</sup>	<b>Pre-authorization Required</b>	\$500 per day copay up to \$2,500 maximum per admit	Plan pays 50% after deductible
<b>Outpatient Mental Disorder/Substance Abuse</b>		You pay \$50 copay/visit after deductible	Plan pays 50% after deductible
<b>Note:</b> There is No Out-of-Network benefit under PLAN Y: COMMUNITY CARE HEALTH PLAN - NJ NETWORK ONLY (BRONZE), 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.			
<b>(1)</b> 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 <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, when services are rendered inside New Jersey, and Labs not sent to Tier 2 providers will not be covered.			
<b>(3)</b> Preventive office visits do not count toward the first 2 Office Visits covered at 100%.			
<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.			
*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.			