Members HealthPlan NJ

Plan H: Network Only Base Plan

NO REFERRALS REQUIRED BENEFIT FEATURES	AETNA - OPEN ACCESS AETNA SELECT IN-NETWORK	OUT-OF-NETWORK
Deductible and Maximum Out-of-Pocket are combined between In-Network and Out-of-Network, if applicable. Maximum Out-of-Pocket includes any Deductible, Coinsurance, medical Copayments and prescription copay/Coinsurance but does not include non-covered amounts above the Plan's Allowable Charges, or Precertification penalties.		
Annual Deductible	None	Not Covered
Annual Maximum Out-of-Pocket	$6,850/Individual; $13,700/Family	Not Covered
Lifetime Maximum	Unlimited	Not Covered
Preventive Care screens		
Preventive Care (wellness office visit)	Plan pays 100%	Not Covered
Preventive Care/screenings	Plan pays 100%	Not Covered
Physician services		
Primary Care Provider	You pay $15 copay/visit	Not Covered
Non - routine gynecological care	You pay $30 copay/visit	Not Covered
Routine pre-natal care	You pay $15 copay (initial visit only)	Not Covered
Specialist Physician	You pay $30 copay/visit	Not Covered
Walk In clinic	You pay $15 copay/visit	Not Covered
Telahealth services (TelaDoc)	General Medicine/Behavioral Health: You pay $15 copay/visit Dermatology: You pay $30 copay/visit	Not Covered
Hospital services		
Inpatient- Facility/Hospital charges(2)	Plan pays 80%	Not Covered
Outpatient Ambulatory Surgery- Facility/Hospital charges(2)	Plan pays 80%	Not Covered
All other Outpatient Care- Facility/Hospital charges	Plan pays 80%	Not Covered
Emergency care		
Urgent Care Center	You pay $30 copay/visit	You pay $30 copay/visit
Emergency admission	Plan pays 80%	Plan pays 80%
Emergency room services	$100 copay/visit, then Plan pays 80% (Copay waived if admitted)	$100 copay/visit, then Plan pays 80% (Copay waived if admitted)
Inpatient Mental Health and Substance Use Disorder(2)		
- Facility/Hospital based	Plan pays 80%	Not Covered
- Physician/professional charges	Plan pays 80%	Not Covered
Outpatient Mental Health and Substance Use Disorder		
- Office based	You pay $15 copay/visit	Not Covered
- All other Outpatient (includes: Partial Hospitalization treatment, intensive outpatient program, skilled behavioral health services, electro-convulsive therapy (ECT), transcranial magnetic stimulation (TMS), psychological and neuropsychological testing, 23 hour observation, peer counseling support by a peer support specialist, outpatient and ambulatory detoxification)	Plan pays 80%	Not Covered
Laboratory services(2)		
- Facility/Hospital based	Plan pays 80%	Not Covered
- Office based or free-standing lab	You pay $15 copay/visit	Not Covered
Other Diagnostic Services (X-rays/MRIs/CT Scans/PET Scans/MRAs/mammography etc.)(2)		
- Facility/Hospital based	Plan pays 80%	Not Covered
- Office based	Plan pays 80%	Not Covered
Outpatient Therapy Services(2)		
- Facility/Hospital based	Plan pays 80%	Not Covered
- Office based or free-standing	Plan pays 80%	Not Covered
Plan notes/requirements:		
Embedded means you can satisfy the Family "Deductible" or the Family "Maximum Out-of-Pocket" with any combination of family members satisfying the amount. However, no one individual may meet more than the individual amount.		
For all Out-of-Network elective and Non-Emergent Services, there is no coverage.		
(2) Some services listed may require Precertification. Network Providers should obtain Precertification for you. You are responsible for Precertification for all services by Out-of-Network Providers. A penalty of 50% of the Plan's allowable amount, to a maximum of $10,000 will be applied if Precertification is not obtained. See the Plan's website at www.membershealthplanni.com for a complete Precertification list.		
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.		