

NO REFERRALS REQUIRED
BENEFIT FEATURES

AETNA - CHOICE POS II
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 | \$500/Individual; \$1,000/Family (Embedded) | \$1,500/Individual; \$3,000/Family (Embedded) |
| Annual Maximum Out-of-Pocket | \$6,850/Individual; \$13,700/Family (Embedded) | \$6,850/Individual; \$13,700/Family (Embedded) |
| Lifetime Maximum | Unlimited | Unlimited |
| Preventive Care/screenings | | |
| Preventive Care (wellness office visit) | Plan pays 100% | Routine care not covered. |
| Preventive Care/screenings | Plan pays 100% | Routine care not covered. |
| Physician services | | |
| Primary Care Provider | You pay \$30 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Non - routine gynecological care | You pay \$50 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Routine pre-natal care | You pay \$30 copay (initial visit only) | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Specialist Physician | You pay \$50 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Walk In clinic | You pay \$30 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Telahealth services (TelaDoc) | General Medicine/Behavioral Health: You pay \$30 copay/visit Dermatology: You pay \$50 copay/visit | N/A |
| Hospital services | | |
| Inpatient- Facility/Hospital charges ⁽²⁾ | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Outpatient Ambulatory Surgery- Facility/Hospital charges ⁽²⁾ | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| All other Outpatient Care- Facility/Hospital charges | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Emergency care | | |
| Urgent Care Center | You pay \$50 copay/visit | You pay \$50 copay/visit |
| Emergency admission | After Deductible, Plan pays 90% | After Deductible, Plan pays 90% |
| Emergency room services | After Deductible and \$100 copay/visit, Plan pays 90% (Copay waived if admitted) | After Deductible and \$100 copay/visit, Plan pays 90% (Copay waived if admitted) |
| Inpatient Mental Health and Substance Use Disorders⁽²⁾ | | |
| - Facility/Hospital based | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| - Physician/professional charges | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Outpatient Mental Health and Substance Use Disorders | | |
| - Office based | You pay \$30 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| - 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) | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Laboratory services⁽²⁾ | | |
| - Facility/Hospital based | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| - Office based or free-standing lab | You pay \$30 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Other Diagnostic Services (X-rays/MRIs/CT Scans/PET Scans/MRAs/mammography etc.)⁽²⁾ | | |
| - Facility/Hospital based | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| - Office based | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Outpatient Therapy Services⁽²⁾ | | |
| - Facility/Hospital based | After Deductible, Plan pays 90% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| - Office based or free-standing | You pay \$50 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| 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. | | |
| (1) For all Out-of-Network elective and Non-Emergent Services, the Plan will pay the Plan's Allowable Charges which will be based on 110% for Professional services and 140% for Facilities of current year Medicare/RBRVS. Refer to definition of Plan's Allowable Charges in Summary Plan Description. | | |
| (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 Charge, to a maximum of \$10,000 will be applied if Precertification is not obtained. See the Plan's website at www.membershealthplannj.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. | | |