

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.

| | IN-NETWORK | OUT-OF-NETWORK |
|--|--|---|
| Annual Deductible | None | Not Covered |
| Annual Maximum Out-of-Pocket | \$4,000/Individual; \$8,000/Family (Embedded) | Not Covered |
| Lifetime Maximum | Unlimited | Not Covered |
| Preventive Care/screenings | | |
| 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 \$30 copay/visit | Not Covered |
| Non - routine gynecological care | You pay \$50 copay/visit | Not Covered |
| Routine pre-natal care | You pay \$30 copay (initial visit only) | Not Covered |
| Specialist Physician | You pay \$50 copay/visit | Not Covered |
| Walk In clinic | You pay \$30 copay/visit | Not Covered |
| Telehealth services (TelaDoc) | General Medicine/Behavioral Health: You pay \$30 copay/visit Dermatology: You pay \$50 copay/visit | Not Covered |
| Hospital services | | |
| Inpatient- Facility/Hospital charges ⁽²⁾ | \$500 copay per day x 5 days per admission, then Plan pays 100% | Not Covered |
| Outpatient Ambulatory Surgery- Facility/Hospital charges ⁽²⁾ | \$300 copay then Plan pays 100% | Not Covered |
| All other Outpatient Care- Facility/Hospital charges | \$300 copay then Plan pays 100% | Not Covered |
| Emergency Care | | |
| Urgent Care Center | You pay \$50 copay/visit | You pay \$50 copay/visit |
| Emergency admission | \$500 copay per day x 5 days per admission, then Plan pays 100% | \$500 copay per day x 5 days per admission, then Plan pays 100% |
| Emergency room services | \$100 copay/visit (Copay waived if admitted) | \$100 copay/visit (Copay waived if admitted) |
| Inpatient Mental Health and Substance Use Disorders⁽²⁾ | | |
| - Facility/Hospital based | \$500 copay per day x 5 days per admission, then Plan pays 100% | Not Covered |
| - Physician/professional charges | Plan pays 100% | Not Covered |
| Outpatient Mental Health and Substance Use Disorders | | |
| - Office based | You pay \$30 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) | \$300 copay then Plan pays 100% | Not Covered |
| Laboratory services⁽²⁾ | | |
| - Facility/Hospital based | Plan pays 100% | Not Covered |
| - Office based or free-standing lab | You pay \$30 copay/visit | Not Covered |
| Other Diagnostic Services (X-rays/MRIs/CT Scans/PET Scans/MRAs/mammography etc.)⁽²⁾ | | |
| - Facility/Hospital based | Plan pays 100% | Not Covered |
| - Office based | Plan pays 100% | Not Covered |
| Outpatient Therapy Services⁽²⁾ | | |
| - Facility/Hospital based | You pay \$50 copay/visit | Not Covered |
| - Office based or free-standing | You pay \$50 copay/visit | 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 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.