Members HealthPlan NJ

# Plan S: HDHP-HSA Compatible High Option

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 | $2,000/Individual; $4,000/Family (Aggregating) | Not Covered |
| Annual Maximum Out-of-Pocket | $6,550/Individual; $13,100/Family (Embedded) | Not Covered |
| Lifetime Maximum | Unlimited | Not Covered |
| **Preventive Care/screenings** | | |
| Preventive Care (wellness office visit) | Plan pays 100% | Not Covered |
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| **Physician services** | | |
| Primary Care Provider | After Deductible, $30 copay/visit | Not Covered |
| Non - routine gynecological care | After Deductible, $50 copay/visit | Not Covered |
| Routine pre-natal care | After Deductible, $30 copay (initial visit only) | Not Covered |
| Specialist Physician | After Deductible, $50 copay/visit | Not Covered |
| Walk In clinic | After Deductible, $30 copay/visit | Not Covered |
| Telehealth services (TelaDoc) | General Medicine/Behavioral Health: After Deductible, $30 copay/visit<br>Dermatology: After Deductible, $50 copay/visit | Not Covered |
| **Hospital services** | | |
| Inpatient- Facility/Hospital charges(2) | After Deductible, $500 copay per admission | Not Covered |
| Outpatient Ambulatory Surgery- Facility/Hospital charges(2) | After Deductible, $200 copay/visit | Not Covered |
| All other Outpatient Care- Facility/Hospital charges | After Deductible, $200 copay/visit | Not Covered |
| **Emergency Care** | | |
| Urgent Care Center | After Deductible, $50 copay/visit | After Deductible, $50 copay/visit |
| Emergency admission | After Deductible, $500 copay per admission | After Deductible, $500 copay per admission |
| Emergency room services | After Deductible and $100 copay/visit, Plan pays 100% (Copay waived if admitted) | After Deductible and $100 copay/visit, Plan pays 100% (Copay waived if admitted) |
| **Inpatient Mental Health and Substance Use Disorders(2)** | | |
| - Facility/Hospital based | After Deductible, $500 copay per admission | Not Covered |
| - Physician/professional charges | After Deductible, Plan pays 100% | Not Covered |
| **Outpatient Mental Health and Substance Use Disorders** | | |
| - Office based | After Deductible, $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) | After Deductible, $200 copay/visit | Not Covered |
| **Laboratory services(2)** | | |
| - Facility/Hospital based | After Deductible, Plan pays 100% | Not Covered |
| - Office based or free-standing lab | After Deductible, $30 copay/visit | Not Covered |
| **Other Diagnostic Services (X-rays/MRIs/CT Scans/PET Scans/MRAs/mammography etc.)(2)** | | |
| - Facility/Hospital based | After Deductible, $200 copay/visit | Not Covered |
| - Office based | After Deductible, Plan pays 100% | Not Covered |
| **Outpatient Therapy Services(2)** | | |
| - Facility/Hospital based | After Deductible, $200 copay/visit | Not Covered |
| - Office based or free-standing | After Deductible, $50 copay/visit | Not Covered |
| **Plan notes/requirements:** | | |
| Aggregating Deductible means that the entire Family "Deductible" must be met either by one person or any combination of members in the family before benefits are paid. Embedded "Maximum Out-of-Pocket" means the individual amount for any one (1) covered family member must be met and then any combination of family members may satisfy the remaining 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. | | |