

Members HealthPlan^{NJ}

**NO REFERRALS REQUIRED
BENEFIT FEATURES**

Plan A: Open Access POS Plan Plus

**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 plan has Out-of-Network benefits. 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.

| | AETNA - CHOICE POS II IN-NETWORK | OUT-OF-NETWORK |
|--|--|---|
| Annual Deductible | None | \$1,000/Individual; \$2,000/Family (Embedded) |
| Annual Maximum Out-of-Pocket | \$4,000/Individual; \$8,000/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 \$15 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Non - routine gynecological care | You pay \$15 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Routine pre-natal care | You pay \$15 copay (initial visit only) | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Specialist Physician | You pay \$75 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Walk In clinic | You pay \$15 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Telehealth services (TelaDoc) | General Medicine/Behavioral Health: You pay \$15 Copay/visit Dermatology: You pay \$75 Copay/visit | N/A |
| Hospital services | | |
| Inpatient- Facility/Hospital charges ⁽²⁾ | Plan pays 100%, after \$250 per admission copay | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Outpatient Ambulatory Surgery- Facility/Hospital charges ⁽²⁾ | Plan pays 100% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| All other Outpatient Care- Facility/Hospital charges | Plan pays 100% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Emergency Care | | |
| Urgent Care Center | You pay \$75 copay/visit | You pay \$75 copay/visit |
| Emergency admission | Plan pays 100%, after \$250 per admission copay | Plan pays 100%, after \$250 per admission copay |
| Emergency room services | \$100 copay/visit (waived if admitted) | \$100 copay/visit (waived if admitted) |
| Inpatient Mental Health and Substance Use Disorders⁽²⁾ | | |
| - Facility/Hospital based | Plan pays 100%, after \$250 per admission copay | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| - Physician/professional charges | Plan pays 100% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Outpatient Mental Health and Substance Use Disorders | | |
| - Office based | You pay \$15 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) | You pay \$15 copay/visit | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Laboratory services⁽²⁾ | | |
| - Facility/Hospital based | Plan pays 100% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| - Office based or free-standing lab | You pay \$15 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 | Plan pays 100% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| - Office based | Plan pays 100% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| Outpatient Therapy Services⁽²⁾ | | |
| - Facility/Hospital based | Plan pays 100% | After Deductible, Plan pays 70% of Plan's Allowable Charges (1) |
| - Office based or free-standing | You pay \$75 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 below may require precertification. In-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.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. | | |