

NO REFERRALS REQUIRED

**TIER 1: MAXIMUM SAVINGS**

**TIER 2: STANDARD SAVINGS**

**TIER 1 - (NJ) AETNA WHOLE HEALTH<sup>SM</sup>- NEW JERSEY-  
AETNA SELECT MULTI-TIER**

**TIER 2 - OPEN ACCESS AETNA SELECT**

**BENEFIT FEATURES**

Deductible and Maximum Out-of-Pocket are combined between Tier 1 and Tier 2. 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.

Benefit Feature	Tier 1 (NJ) Aetna Whole Health <sup>SM</sup> -New Jersey-Aetna Select Multi-Tier	Tier 2 Standard Savings Tier 2 - Open Access Aetna Select
Annual Deductible	None	\$2,500/Individual; \$5,000/family (Embedded)
Annual Maximum Out-of-Pocket	\$3,000/Individual; \$6,000/Family (Embedded)	\$8,550/Individual; \$17,100/Family (Embedded)
Lifetime Maximum	Unlimited	Unlimited
<b>Preventive Care/screenings</b>		
Preventive Care (wellness office visit)	Plan pays 100%	Plan pays 100%
Preventive Care/screenings	Plan pays 100%	Plan pays 100%
<b>Physician services</b>		
Primary Care Provider	First 2 PCP visits covered at 100%; subsequent visits, You pay \$25 copay/visit (Preventive office visits do not count toward the first 2 PCP office visit covered at 100%)	After Deductible, Plan pays 70%
Non - routine gynecological care	You pay \$50 copay/visit	After Deductible, Plan pays 70%
Routine pre-natal care	You pay \$25 copay (initial visit only)	After Deductible, Plan pays 70%
Specialist Physician	You pay \$50 copay/visit	After Deductible, Plan pays 70%
Walk In clinic	You pay \$25 copay	After Deductible, Plan pays 70%
Telehealth services (TelaDoc)	General Medicine/Behavioral Health: You pay \$25 Copay/visit Dermatology: You pay \$50 Copay/visit	N/A
<b>Hospital services</b>		
Inpatient- Facility/Hospital charges <sup>(2)</sup>	Plan pays 100% after \$500 copay per admission	After Deductible, Plan pays 70%
Outpatient Ambulatory Surgery- Facility/Hospital charges <sup>(2)</sup>	\$250 copay then Plan pays 100%	After Deductible, Plan pays 70%
All other Outpatient Care- Facility/Hospital charges	\$50 copay then Plan pays 100%	After Deductible, Plan pays 70%
<b>Emergency Care</b>		
Urgent Care Center	You pay \$50 copay/visit	You pay \$50 copay/visit
Emergency admission	Plan pays 100% after \$500 copay per admission	Plan pays 100% after \$500 copay per admission
Emergency room services	\$100 copay/visit, then Plan pays 100% (Copay waived if admitted)	\$100 copay/visit, then Plan pays 100% (Copay waived if admitted)
<b>Inpatient Mental Health and Substance Use Disorders<sup>(2)</sup></b>		
- Facility/Hospital based	Plan pays 100% after \$500 per admission	After Deductible, Plan pays 70%
- Physician/professional charges	Plan pays 100%	After Deductible, Plan pays 70%
<b>Outpatient Mental Health and Substance Use Disorders</b>		
- Office based	You pay \$25 copay/visit	After Deductible, Plan pays 70%
- 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 \$50 copay/visit	After Deductible, Plan pays 70%
<b>Laboratory services<sup>(2)</sup></b>		
- Facility/Hospital based	Plan pays 100%	After Deductible, Plan pays 70%
- Office based or free-standing lab	You pay \$25 copay/visit	After Deductible, Plan pays 70%
<b>Other Diagnostic Services (X-rays/MRIs/CT Scans/PET Scans/MRAs/mammography etc.)<sup>(2)</sup></b>		
- Facility/Hospital based	Plan pays 100%	After Deductible, Plan pays 70%
- Office based	Plan pays 100%	After Deductible, Plan pays 70%
<b>Outpatient Therapy Services<sup>(2)</sup></b>		
- Facility/Hospital based	You pay \$50 copay/visit	After Deductible, Plan pays 70%
- Office based or free-standing	You pay \$50 copay/visit	After Deductible, Plan pays 70%
<b>Plan notes/requirements:</b>		

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 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](http://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.