

NO REFERRALS REQUIRED

AETNA - OPEN ACCESS AETNA SELECT

### BENEFIT FEATURES

### 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.

Annual Deductible	\$2,500/Individual; \$5,000/Family (Embedded)	Not Covered
Annual Maximum Out-of-Pocket	\$8,550/Individual; \$17,100/Family (Embedded)	Not Covered
Lifetime Maximum	Unlimited	Not Covered
<b>Preventive Care screens</b>		
Preventive Care (wellness office visit)	Plan pays 100%	Not Covered
Preventive Care/screenings	Plan pays 100%	Not Covered
<b>Physician services</b>		
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
<b>Hospital services</b>		
Inpatient- Facility/Hospital charges <sup>(2)</sup>	\$500 copay per admission, after Deductible, then Plan pays 70%	Not Covered
Outpatient Ambulatory Surgery- Facility/Hospital charges <sup>(2)</sup>	After Deductible, Plan pays 70%	Not Covered
All other Outpatient Care- Facility/Hospital charges	After Deductible, Plan pays 70%	Not Covered
<b>Emergency Care</b>		
Urgent Care Center	You pay \$50 copay/visit	You pay \$50 copay/visit
Emergency admission	\$500 copay per admission, after Deductible, then Plan pays 70%	\$500 copay per admission, after Deductible, then Plan pays 70%
Emergency room services	After Deductible and \$100 copay/visit, Plan pays 70% (Copay waived if admitted)	After Deductible and \$100 copay/visit, Plan pays 70% (Copay waived if admitted)
<b>Inpatient Mental Health and Substance Use Disorders<sup>(2)</sup></b>		
- Facility/Hospital based	\$500 copay per admission, after Deductible, then Plan pays 70%	Not Covered
- Physician/professional charges	After Deductible, Plan pays 100%	Not Covered
<b>Outpatient Mental Health and Substance Use Disorders</b>		
- Office based	You pay \$30 copay/visit	Not Covered
- All other Outpatient (includes: Partial Hospitalization treatment, intensive outpatient program, skilled behavioral health services, electroconvulsive 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 70%	Not Covered
<b>Laboratory services<sup>(2)</sup></b>		
- Facility/Hospital based	After Deductible, Plan pays 70%	Not Covered
- Office based or free-standing lab	You pay \$30 copay/visit	Not Covered
<b>Other Diagnostic Services (X-rays/MRIs/CT Scans/PET Scans/MRAs/mammography etc.)<sup>(2)</sup></b>		
- Facility/Hospital based	After Deductible, Plan pays 70%	Not Covered
- Office based	After Deductible, Plan pays 70%	Not Covered
<b>Outpatient Therapy Services<sup>(2)</sup></b>		
- Facility/Hospital based	After Deductible, Plan pays 70%	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 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.