

Waterford Township - Medical Benefits Overview - SNJ Fund/Aetna - Effective 5/1/2025

SNJ Fund/ Aetna Plan Name	Aetna Choice POS II \$10 Open Access	Aetna Choice POS II \$15 Open Access	Aetna Choice POS II \$15/\$25 Open Access	Aetna Choice POS II \$20/\$30 Open Access	Aetna Choice POS II \$20/\$35 Open Access	Aetna HMO \$10
Replaces SHBP Plan	NJ Direct/Aetna Freedom 10	NJ Direct/Aetna Freedom 15	NJ Direct/Aetna Freedom 1525	NJ Direct/Aetna Freedom 2030	NJ Direct/Aetna Freedom 2035	HORIZON HMO
IN-NETWORK (IN)						
Service Area Available	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide Aetna HMO Network Referral required
Specialist Referral	No referral required	No referral required	No referral required	No referral required	No referral required	
Deductible						
Individual	\$0	\$0	\$0	\$0	\$200	See DME
Family	\$0	\$0	\$0	\$0	\$500	See DME
Coinsurance	10%	10%	10%	10%	20% after deductible	0%
Coinsurance Out-of-Pocket Maximum						
Individual	None	\$400	\$400	\$800	\$2,000	Not applicable
Family	None	\$1,000	\$1,000	\$2,000	\$5,000	Not applicable
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)						
Individual	\$400	\$7,360	\$7,360	\$7,360	\$7,360	\$7,360
Family	\$1,000	\$14,720	\$14,720	\$14,720	\$14,720	\$14,720
HEALTH CARE SERVICES						
Primary Care Office Visit	\$10	\$15	\$15	\$20	\$20	\$10
Annual Routine Physical (In-Network Only)	\$0	\$0	\$0	\$0	\$0	\$0
Direct Primary Care	\$0	\$0	\$0	\$0	\$0	Not available
First Responders Doctors Office (FRDOCS)	\$0	\$0	\$0	\$0	\$0	\$0
Telemedicine	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply
Specialist Office Visit	\$10	\$15	\$25	\$30/adult, \$20/child	\$35	\$10
Annual Routine Vision (In-Network Only)	\$10	\$15	\$25	\$30/adult, \$20/child	\$35	\$10
Chiropractic	\$10	\$15	\$25	\$30/adult, \$20/child	\$35	\$10
Physical/Occupational/Speech Therapy	\$10	\$15	\$25	\$30/adult, \$20/child	\$35 office visit/ 20% after deductible at an outpatient facility	\$10
DIAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING						
Outpatient Laboratory/Radiology/Advanced Imaging	\$0	\$0	\$0	\$0	20% after deductible	\$0
Freestanding Laboratory/Radiology/Advanced Imaging	\$0	\$0	\$0	\$0	20% after deductible	\$0
EMERGENCY/URGENT MEDICAL SERVICES						
Urgent Care Center	\$10	\$15	\$25	\$30/adult, \$20/child	\$35	\$10
Emergency Room	\$75	\$100	\$100	\$125	\$300	\$85
Ambulance	10%	10%	10%	10%	20% after deductible	\$0
OTHER SERVICES						
Inpatient Facility	\$0	\$0	\$0	\$0	20% after deductible	\$0
Outpatient Facility	\$0	\$0	\$0	\$0	20% after deductible	\$0
Outpatient Behavioral Health	\$10	\$15	\$25	\$30/adult, \$20/child	\$35 office visit/ 20% after deductible	\$10
Durable Medical Equipment (DME)	10%	10%	10%	10%	\$100 deductible, then covered in full	
OUT-OF-NETWORK (OON)						
Deductible - Individual	\$100	\$100	\$100	\$200	\$800	
Deductible - Family	\$250	\$250	\$250	\$500	\$2,000	
Coinsurance after Deductible	20%	30%	30%	30%	40%	
Out-of-Pocket Coinsurance Maximum - Individual	\$2,000	\$2,000	\$2,000	\$5,000	\$6,500	
Out-of-Pocket Coinsurance Maximum - Family	\$5,000	\$5,000	\$5,000	\$12,500	\$13,000	
Inpatient Hospital Deductible	\$200/stay	\$200/stay	\$200/stay	\$500/stay	\$600/stay	

-Preauthorization may be required for certain services.

-All plans with an out-of-network benefit have specified dollar limits for out-of-network chiropractic (\$35), physical therapy (\$52) and acupuncture (\$60).

-This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical plans. Some plan limitations may apply. Please refer to the plan documents provided by the carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.