Waterford Township - Medical Benefits Overview - SNJ Fund/Aetna

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 (Open Access)	Aetna Choice POS II $20/$35 (No Deductible) (Open Access)
IN-NETWORK (IN)					
Service Area Available	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide
Specialist Referral	No referral required	No referral required	No referral required	No referral required	No referral required
Deductible					
Individual	$0	$0	$0	$0	$0
Family	$0	$0	$0	$0	$0
Coinsurance	10%	10%	10%	10%	0%
Coinsurance Out-of-Pocket Maximum					
Individual	None	None	None	None	None
Family	None	None	None	None	None
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)					
Individual	$400	$400	$400	$800	$1,000
Family	$1,000	$1,000	$1,000	$2,000	$2,500
HEALTH CARE SERVICES					
Primary Care Office Visit	$10	$15	$15	$20	$20
Annual Routine Physical (In-Network Only)	$0	$0	$0	$0	$0
Telemedicine (CVS Virtual Care)	$0	$0	$0	$0	$0
Specialist Office Visit	$10	$15	$25	$20	$35
Annual Routine Vision (In-Network Only)	$10	$15	$25	$20	$35
Chiropractic	$10	$15	$25	$20	$35
Physical/Occupational/Speech Therapy	$10	$15	$25	$20	$35
DIAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING					
Outpatient Laboratory/Radiology/Advanced Imaging	$0	$0	$0	$0	$0 ($35 Copay for X-rays only)
Freestanding Laboratory/Radiology/Advanced Imaging	$0	$0	$0	$0	$0 ($35 Copay for X-rays only)
EMERGENCY/URGENT MEDICAL SERVICES					
Urgent Care Center	$10	$15	$25	$20	$35
Emergency Room	$25	$50	$75	$125	$150
Ambulance	10%	10%	10%	10%	0%
OTHER SERVICES					
Inpatient Facility	$0	$0	$0	$0	$100 Copay ($500 max/admission)
Outpatient Facility	$0	$0	$0	$0	$0
Outpatient Behavioral Health	$10	$15	$25	$20	$35
Durable Medical Equipment (DME)	10%	10%	10%	10%	0%
OUT-OF-NETWORK (OON)					
Deductible - Individual	$100	$100	$100	$200	$500
Deductible - Family	$250	$250	$250	$500	$1000
Coinsurance after Deductible	20%	30%	30%	30%	30%
Out-of-Pocket Coinsurance Maximum - Individual	$2,000	$2,000	$2,000	$5,000	$2,500
Out-of-Pocket Coinsurance Maximum - Family	$5,000	$5,000	$5,000	$12,500	$5,000
Inpatient Hospital Deductible	$200/stay	$200/stay	$200/stay	$500/stay	$500/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.

SNJ Fund/ Aetna Plan Name	Aetna Choice POS II $20/$35 (With Deductible) (Open Access)	Aetna HMO $10	Aetna Whole Health	
IN-NETWORK (IN)				
Service Area Available	Nationwide	Nationwide Aetna HMO Network	NJ only	Nationwide
Specialist Referral	No referral required	Referral required	No referral required	No referral required
Deductible				
Individual	$200	$100 for DME Only	$0	$1,500
Family	$500	$100 for DME Only	$0	$3,000
Coinsurance	20% after deductible	0%	0%	20% after deductible
Coinsurance Out-of-Pocket Maximum				
Individual	Not applicable	Not applicable	Not applicable	Not applicable
Family	Not applicable	Not applicable	Not applicable	Not applicable
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)				
Individual	$2,000	$8,480	$2,500	$4,500
Family	$5,000	$16,960	$5,000	$9,000
HEALTH CARE SERVICES				
Primary Care Office Visit	$20	$10	$5	$20
Annual Routine Physical (In-Network Only)	$0	$0	$0	$0
Telemedicine	$0	$0	$0	$0
Specialist Office Visit	$35	$10	$15	$30
Annual Routine Vision (In-Network Only)	$35	$10	$15	$30
Chiropractic	$35	$10	$15	$30
Physical/Occupational/Speech Therapy	$35 office visit/ 20% after deductible at an outpatient facility	$10	$5 office visit/ $15 outpatient facility	$20 office visit/ 20% after deductible at an outpatient facility
DIAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING				
Outpatient Laboratory/Radiology/Advanced Imaging	20% after deductible	$0	$15	20% after deductible
Freestanding Laboratory/Radiology/Advanced Imaging	20% after deductible	$0	$0	$0
EMERGENCY/URGENT MEDICAL SERVICES				
Urgent Care Center	$35	$10	$15	$30
Emergency Room	$300	$35	$100	$100
Ambulance	20% after deductible	$0	$0	$0
OTHER SERVICES				
Inpatient Facility	20% after deductible	$0	$150 per admission	20% after deductible
Outpatient Facility	20% after deductible	$0	$150	20% after deductible
Outpatient Behavioral Health	$35 office visit 20% after deductible at an outpatient facility	$10	$15	$30 office visit/ 20% after deductible at an outpatient facility
Durable Medical Equipment (DME)	20% after deductible	$100 deductible, then covered in full	$0	$0
OUT-OF-NETWORK (OON)				
Deductible - Individual	$800	No out-of-network benefits	No out-of-network benefits	No out-of-network benefits
Deductible - Family	$2,000			
Coinsurance after Deductible	40%			
Out-of-Pocket Coinsurance Maximum - Individual	$6,500			
Out-of-Pocket Coinsurance Maximum - Family	$13,000			
Inpatient Hospital Deductible	$600/stay			

Waterford Township

Prescription Benefits Overview - SNJ Fund/Express Scripts

SNJ Fund / Express Scripts	$3/$10/$10	$3/$10/$10	$7/$16/$35	$3/$18/$46	$7/$21/DIFF	$3/$10/$10	$0/$30/$60
Corresponding SNJ Fund Medical Plan	**Aetna Choice POS II $10**	**Aetna Choice POS II $15**	**Aetna Choice POS II $15/$25 Aetna Whole Health**	**Aetna Choice POS II $20**	**Aetna Choice POS II $20/$35 (With Deductible) (Open Access)**	**Aetna HMO $10**	**Aetna Choice POS II $20/$35 (No Deductible) (Open Access)**
Retail: Generic Copayments	$3	$3	$7	$3	$7	$3	$0
Retail: Preferred Brand Copayments	$10	$10	$16	$18	$21	$10	$30
Retail: Non-Preferred Brand Copayments	$10	$10	$35	$46	Member pays difference	$10	$60
Retail: Brand w/ Generic Equivalent	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference
Mail: Generic Copayments	$0	$0	$0	$0	$0	$0	$0
Mail: Preferred Brand Copayments	$15	$15	$40	$36	$52	$15	$60
Mail: Non-Preferred Brand Copayments	$15	$15	$88	$92	Member pays difference	$15	$120
Mail: Brand w/ Generic Equivalent	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference
Prescription Drug annual Out-of-Pocket Maximum (Individual/Family)	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680

Member Pays Difference - You pay the cost difference between the brand drug and the generic drug.

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