Pompton Lakes Board of Education
Change in Medical Benefits Carrier

The purpose of this memorandum is to advise you of a change in our medical insurance carrier.

Effective January 1, 2027, the Pompton Lakes Board of Education will be providing medical coverage through the SHIF with Aetna as the medical carrier. The SHIF has provided the board with an "equal to or better" letter regarding the medical coverage. We will no longer be participating with Horizon Blue Cross Blue Shield for our medical benefits.

The prescription coverage will remain with Benecard.
The dental coverage will remain with Delta Dental.
Only the medical coverage will be transitioned to the SHIF/Aetna.

To obtain answers to your questions about the transition we have coordinated with the Integrity Consulting Group, to provide an orientation/informational meeting and a virtual ZOOM meeting. This will give you an opportunity to have your questions answered.

The meeting format will consist of an overview of the transition to the SHIF/Aetna, what you as an employee need to know, along with answers to your questions. Please review the attached materials prior to the meeting.

Please note this is not considered your open enrollment period. Open enrollment will be held in spring with an effective change date of 7/1/2027. You will be automatically transferred to the corresponding plan you are currently enrolled in. Please see the plan mapping on the next page. If you recently moved and have not changed your address with Horizon please advise Patti Feehan. Your new Aetna ID cards will be mailed to your home address currently on the Horizon system.

Orientation/Informational Meetings
High School: Monday, November 16th at 3:30pm
Zoom: Wednesday, November 18th at 3:15pm

Pompton Lakes Board of Education
Equivalent Plan Mapping
Current Horizon Plans to SHIF Aetna Plans

Horizon Direct Access $10	→	**Aetna Choice POS II $10 (Open Access)**
Horizon Direct Access $15	→	**Aetna Choice POS II $15 (Open Access)**
Horizon NJEHP	→	**Aetna Choice POS II NJEHP**
Horizon Garden State	→	**Aetna Garden State**

You will be automatically enrolled in the corresponding plan.

November 2026

Pompton Lakes Board of Education - SHIF Aetna Choice POS II $10 & $15 plans

	AETNA CHOICE POS II $10 (OPEN ACCESS)	AETNA CHOICE POS II $15 (OPEN ACCESS)
REPLACING CURRENT PLAN	Horizon $10 Direct Access	Horizon $15 Direct Access
Is a PCP Selection required? (*Yes or No)*	No	No
Are Referrals required? *(Yes or No)*	No	No
Deductible In Network - Individual/Family	None	None
Deductible Out of Network- Individual/Family	$100/$250	$100/$250
Max Out of Pocket In Network - Individual/Family	$400/$800	$400/$800
Max Out of Pocket Out of Network- Individual/Family	$2,000/$5,000	$2,000/$5,000
Routine Well Adult Exam	No deductible 100%	No deductible 100%
Routine Well Adult Exam - Out of Network	No deductible 80%	No deductible 70%
Routine Gyn Exam - In Network	No deductible 100%	No deductible 100%
Routine Gyn Exam - Out of Network	No deductible 80%	No deductible 70%
Routine Mammography - In Network	No deductible 100%	No deductible 100%
Routine Mammography - Out of Network	No deductible 80%	No deductible 70%
Routine Well Child Exams - In Network	No deductible 100%	No deductible 100%
Routine Well Child Exams - Out of Network	No deductible 80%	No deductible 70%
Routine Eye Exam - In Network	$10 copay	$15 copay
Routine Eye Exam - Out of Network	Not Covered	Not Covered
Routine Eye Exam Frequency	1 per calendar year	1 per calendar year
Vision Eyewear Reimbursement Allowance and Frequency	Not Covered	Not Covered
PCP Office Visit - In Network	$10 copay	$15 copay
PCP Office Visit - Out of Network	After deductible 80%	After deductible 70%
Specialist Office Visit - In Network	$10 copay	$15 copay
Specialist Office Visit - Out of Network	After deductible 80%	After deductible 70%
Maternity Prenatal Care - In Network	$10 copay for initial visit then 100%	$15 copay for initial visit then 100%
Maternity Prenatal Care - Out of Network	After deductible 80%	After deductible 70%
Diagnostic X-Ray/Lab in Office - In Network	No deductible 100%	No deductible 100%
Diagnostic X-Ray/Lab in Office - Out of Network	After deductible 80%	After deductible 70%
Diagnostic X-Ray/Lab in Facility - In Network	No deductible 100%	No deductible 100%
Diagnostic X-Ray/Lab in Facility - Out of Network	After deductible 80%	After deductible 70%
Complex Imaging in Facility - In Network	No deductible 100%	No deductible 100%
Complex Imaging in Facility - Out of Network	After deductible 80%	After deductible 70%
Urgent Care - In Network	$10 copay	$15 copay
Urgent Care - Out of Network	After deductible 80%	After deductible 70%
Emergency Room - In Network & Out of Network	$25 copay	$50 copay
Ambulance - In Network	No deductible 90%	No deductible 90%
Ambulance - Out of Network	After deductible 80%	After deductible 70%
Is Non-Emergency Ambulance transport covered?	No	No
Inpatient Hospital Services - In Network	No deductible 100%	No deductible 100%
Inpatient Hospital Services - Out of Network	After deductible 80%	After deductible 70%
Per Confinement Copay- In Network	N/A	N/A
Per Confinement Copay- Out of Network	N/A	N/A
Outpatient Hospital Services - In Network	No deductible 100%	No deductible 100%
Outpatient Hospital Services - Out of Network	After deductible 80%	After deductible 70%

	AETNA CHOICE POS II $10 (OPEN ACCESS)	AETNA CHOICE POS II $15 (OPEN ACCESS)
Outpatient Surgery - In Network	No deductible 100%	No deductible 100%
Outpatient Surgery - Out of Network	After deductible 80%	After deductible 70%
Skilled Nursing Facility - In Network	No deductible 100%	No deductible 100%
Skilled Nursing Facility - Out of Network	After deductible 80%	After deductible 70%
Skilled Nursing Facility - Limits *(# of days per calendar year)*	120 IN / 60 OON - Combined Max	120 IN / 60 OON - Combined Max
Home Health Care - In Network	No deductible 100%	No deductible 100%
Home Health Care - Out of Network	After deductible 80%	After deductible 70%
Home Health Care Limits *(# of visits per calendar year)*	No Limit	No Limit
Hospice - In Network	No deductible 100%	No deductible 100%
Hospice - Out of Network	After deductible 80%	After deductible 70%
Durable Medical Equipment - In Network	No deductible 90%	No deductible 90%
Durable Medical Equipment - Out of Network	After deductible 80%	After deductible 70%
Orthotics/Prosthetics - In Network	$10 copay	$15 copay
Orthotics/Prosthetics- Out of Network	After deductible 80%	After deductible 70%
Diabetic Supplies - In Network	No deductible 90%	No deductible 90%
Diabetic Supplies - Out of Network	After deductible 80%	After deductible 70%
Acupuncture -include visit limits - In Network	$10 copay	$15 copay
Acupuncture - include visit limits - Out of Network	After deductible 80%	After deductible 70%
Short Term Rehab - Physical Therapy - In Network	$10 copay	$15 copay
Short Term Rehab - Physical Therapy - Out of Network	After deductible 80%	After deductible 70%
Physical Therapy Limits *(# of visits per calendar year)*	Unlimited	Unlimited
Short Term Rehab - Occupational Therapy - In Network	$10 copay	$15 copay
Short Term Rehab - Occupational Therapy - Out of Network	After deductible 80%	After deductible 70%
Occupational Therapy Limits? *(# of visits per calendar year)*	Unlimited	Unlimited
Short Term Rehab - Speech Therapy - In Network	$10 copay	$15 copay
Short Term Rehab - Speech Therapy - Out of Network	After deductible 80%	After deductible 70%
Speech Therapy Limits *(# of visits per calendar year)*	Unlimited	Unlimited
Spinal Manipulation/Chiro - In Network	$10 copay	$15 copay
Spinal Manipulation/Chiro - Out of network	After deductible 80%	After deductible 70%
Spinal Manipulation/Chiro Limits *(# visits per calendar year)*	30	30
Mental Health/Substance Abuse Inpatient - In Network	No deductible 100%	No deductible 100%
Mental Health/Substance Abuse Inpatient - Out Network	After deductible 80%	After deductible 70%
Mental Health/Substance Abuse In Network - Office Setting	$10 copay	$15 copay
Mental Health/Substance Abuse Out of Network - Office Setting	After deductible 80%	After deductible 70%

SHIF NJEHP	
	Aetna Choice POS II NJEHP
REPLACING CURRENT PLAN	**Horizon NJEHP**
Is a PCP Selection required? (*Yes or No)*	No
Are Referrals required? *(Yes or No)*	No
Deductible In Network - Individual/Family	None
Deductible Out of Network- Individual/Family	$350/$700
Max Out of Pocket In Network - Individual/Family	$500/$1000
Max Out of Pocket Out of Network- Individual/Family	$2000/$5000
Routine Well Adult Exam - In Network	No deductible 100%
Routine Well Adult Exam - Out of Network	not covered
Routine Gyn Exam - In Network	No deductible 100%
Routine Gyn Exam - Out of Network	After deductible 70%
Routine Mammography - In Network	No deductible 100%
Routine Mammography - Out of Network	After deductible 70%
Routine Well Child Exams - In Network	No deductible 100%
Routine Well Child Exams - Out of Network	not covered - immunizations 70% no deductible for children under 12 months
Routine Eye Exam - In Network	$15 copay
Routine Eye Exam - Out of Network	not covered
Routine Eye Exam Frequency	1 per calendar year
Vision Eyewear Reimbursement Allowance and Frequency	not covered
PCP Office Visit - In Network	$10 copay
PCP Office Visit - Out of Network	After deductible 70%
Specialist Office Visit - In Network	$15 copay
Specialist Office Visit - Out of Network	After deductible 70%
Maternity Prenatal Care - In Network	$15 copay for the initial visit then 100%
Maternity Prenatal Care - Out of Network	After deductible 70%
Diagnostic X-Ray/Lab in Office - In Network	No deductible 100% but if billed as part of an Office Visit, copay will apply
Diagnostic X-Ray/Lab in Office - Out of Network	After deductible 70%
Diagnostic X-Ray/Lab in Facility - In Network	No deductible 100%
Diagnostic X-Ray/Lab in Facility - Out of Network	After deductible 70%
Complex Imaging in Facility - In Network	No deductible 100%
Complex Imaging in Facility - Out of Network	After deductible 70%
Urgent Care - In Network	$15 copay
Urgent Care - Out of Network	After deductible 70%
Emergency Room - In Network & Out of Network	$125 copay
Ambulance - In Network	No deductible 90%
Ambulance - Out of Network	After deductible 70%
Is Non-Emergency Ambulance transport covered?	No
Inpatient Hospital Services - In Network	No deductible 100%
Inpatient Hospital Services - Out of Network	After deductible 70%
Per Confinement Copay- In Network	N/A
Per Confinement Copay- Out of Network	N/A
Outpatient Hospital Services - In Network	No deductible 100%
Outpatient Hospital Services - Out of Network	After deductible 70%

Outpatient Surgery - In Network	No deductible 100%
Outpatient Surgery - Out of Network	After deductible 70%
Skilled Nursing Facility - In Network	No deductible 100%
Skilled Nursing Facility - Out of Network	After deductible 70%
Skilled Nursing Facility - Limits *(# of days per calendar year)*	120 In Network, 60 Out of Network
Home Health Care - In Network	No deductible 100%
Home Health Care - Out of Network	After deductible 70%
Home Health Care Limits *(# of visits per calendar year)*	No limit
Hospice - In Network	No deductible 100%
Hospice - Out of Network	After deductible 70%
Durable Medical Equipment - In Network	No deductible 90%
Durable Medical Equipment - Out of Network	After deductible 70%
Orthotics/Prosthetics - In Network	$15 copay
Orthotics / Prosthetics- Out of Network	After deductible 70%
Diabetic Supplies - In Network	No deductible 90%
Diabetic Supplies - Out of Network	After deductible 70%
Acupuncture - In Network	$15 copay
Acupuncture - Out of Network	Lesser of $60/visit or 75% of In-network cost/visit
Short Term Rehab - Physical Therapy - In Network	$15 copay
Short Term Rehab - Physical Therapy - Out of Network	Lesser of $52/visit or 75% of In-network cost/visit
Physical Therapy Limits *(# of visits per calendar year)*	no limit
Short Term Rehab - Occupational Therapy - In Network	$15 copay
Short Term Rehab - Occupational Therapy - Out of Network	After deductible 70%
Occupational Therapy Limits? *(# of visits per calendar year)*	no limit
Short Term Rehab - Speech Therapy - In Network	$15 copay
Short Term Rehab - Speech Therapy - Out of Network	After deductible 70%
Speech Therapy Limits *(# of visits per calendar year)*	no limit
Spinal Manipulation/Chiro - In Network	$15 copay
Spinal Manipulation/Chiro - Out of network	Lesser of $35/visit or 75% of in-network cost/visit
Spinal Manipulation/Chiro Limits *(# visits per calendar year)*	30 visits
Mental Health / Substance Abuse Inpatient - In Network	No deductible 100%
Mental Health / Substance Abuse Inpatient - Out Network	After deductible 70%
Mental Health / Substance Abuse- In Network - Office Setting	$15 copay
Mental Health / Substance Abuse - Out of Network - Office Setting	After deductible 70%

SHIF Garden State Plan

NJ Garden State Plans provide services performed by providers located within the state of New Jersey Only. Services performed by a provider located outside the state of New Jersey is not covered.

	In-Network Designated	Out-Of-Network/Non Designated Providers
REPLACING CURRENT PLAN	**Horizon Garden State**	**Horizon Garden State**
Is a PCP Selection required? (*Yes or No)*	No	No
Are Referrals required? *(Yes or No)*	No	No
Deductible - Individual/Family	None	$350/$700
Max Out of Pocket In Network - Individual/Family	$500/$1000	$2000/$5000
Routine Well Adult Exam	No deductible 100%	not covered
Routine Gyn Exam	No deductible 100%	After deductible 70%
Routine Mammography	No deductible 100%	After deductible 70%
Routine Well Child Exams	100% - per age/frequency schedule	not covered - immunizations 70% no deductible for children under 12 months
Routine Eye Exam	$15 copay	not covered
Routine Eye Exam Frequency	1 per calendar year	not covered
Vision Eyewear Reimbursement Allowance and Frequency	not covered	not covered
PCP Office Visit	$10 copay	After deductible 70%
Specialist Office Visit	$15 copay	After deductible 70%
Maternity Prenatal Care	$15 copay for initial visit then 100%	After deductible 70%
Diagnostic X-Ray/Lab in Office	No deductible 100% but if billed as part of an Office Visit, copay will apply	After deductible 70%
Diagnostic X-Ray/Lab in Facility	No deductible 100%	After deductible 70%
Complex Imaging in Facility	No deductible 100%	After deductible 70%
Urgent Care	$15 copay	After deductible 70%
Emergency Room - In Network & Out of Network	$125 copay	$125 copay
Is Non-Emergency care at ER covered?	No	No
Ambulance	No deductible 90%	After deductible 70%
Is Non-Emergency Ambulance transport covered?	No	No
Inpatient Hospital Services	No deductible 100%	After deductible 70%
Per Confinement Copay	N/A	N/A
Outpatient Hospital Services	No deductible 100%	After deductible 70%
Outpatient Surgery	No deductible 100%	After deductible 70%
Skilled Nursing Facility	No deductible 100%	After deductible 70%
Skilled Nursing Facility - Limits *(# of days per calendar year)*	120	60
Home Health Care	100%	After deductible 70%
Home Health Care Limits *(# of visits per calendar year)*	No limit	No limit
Hospice	No deductible 100%	After deductible 70%
Durable Medical Equipment	No deductible 90%	After deductible 70%
Orthotics / Prosthetics	$15 copay	After deductible 70%
Diabetic Supplies	No deductible 90%	After deductible 70%
Acupuncture	$15 copay	Lesser of $60/visit or 75% of In-network cost/visit
Short Term Rehab - Physical Therapy	$15 copay	Lesser of $52/visit or 75% of In-network cost/visit
Physical Therapy Limits *(# of visits per calendar year)*	no limit	no limit
Short Term Rehab - Occupational Therapy	$15 copay	After deductible 70%
Occupational Therapy Limits? *(# of visits per calendar year)*	no limit	no limit
Short Term Rehab - Speech Therapy	$15 copay	After deductible 70%
Speech Therapy Limits *(# of visits per calendar year)*	no limit	no limit
Spinal Manipulation/Chiro	$15 copay	Lesser of $35/visit or 75% of in-network cost/visit
Spinal Manipulation/Chiro Limits *(# visits per calendar year)*	30 visits	30 visits
Mental Health Inpatient	100%	After deductible 70%
Mental Health Outpatient - Office Setting	$15 copay	After deductible 70%

Pompton Lakes Board of Education

DocFind Instructions – Initial Enrollment

Step 1: Visit Aetna's website at www.aetna.com

Step 2: At the top of the webpage, click on "**Find A Doctor**"

Step 3: On right side of page under the section labeled "**Don't have a member account?"** select "**Plan from an employer**" (*1st choice on the list*)

Step 4: Under Continue as a Guest, enter you zip code, city, state, or county

Step 5: You will be asked to **"Select a Plan";** use the Key below to help you make the correct selection:

If you are enrolled in a	DocFind Plan selection is…
Aetna Choice POS II $10 and $15 Open Access *(Formerly Horizon Direct Access $10, Horizon Direct Access $15)*	Category Heading = **Aetna Open Access Plans** Name = Aetna Choice POS II (Open Access)
Aetna Choice POS II NJEHP *(Formerly Horizon NJEHP)*	Category Heading = **Aetna Open Access Plans** Plan Name = Aetna Choice POS II (Open Access)
Aetna Garden State Plan *(Formerly Horizon GSHP)*	Category Heading = **Aetna Whole Health Plan** Plan Name = (NJ) Aetna Whole Health New Jersey Choice POS II

Step 6: Click **CONTINUE** to search for the type of provider