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%