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%