Southern Coastal FUND

WATERFORD TWP BOE - 2021 PLAN OPTIONS

	AETNA HNO $10		AETNA HNO $15		AETNA HNO NJEHP $10/$15		Aetna HMO ($10)	AETNA HDHP [HSA Compatible]	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network
Deductible									
Individual	None	$100	None	$100	None	$350	$100 on select services	$1,500.00	
Family	None	$250	None	$250	None	$700		$3,000.00	
Out of Pocket Annual Limit									
Individual	$400	$2,000	$5,880	$2,000	$500	$2,000	$5,880	$2,500	$3,500
Family	$1,000	$5,000	$11,760	$5,000	$1,000	$5,000	$11,760	$5,000	$7,000
Out of Network Restrictions	n/a	none	n/a	none	n/a	**Chiropractic, Acupuncture & PT have Limited Fee Schedule*** **	n/a	n/a	none
Referreal by Primary Care Physician Required	Not Required	Not Applicable	Not Required	Not applicable	Not Required	Not applicable	[1] See footnote	Not Required	Not applicable
Preventive Care									
PrevCare/Screenings/Immunizations (as per ACA Guidelines	$0 copay	20% after Deductible	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	$0 copay	Not Covered
Physician's Office Visit									
Primary Care Services	$10 Copay	20% after Deductible	$15 copay	30% after Deductible	$10 copay	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible
Specialist Services	$10 Copay	20% after Deductible	$15 copay	30% after Deductible	$15 copay	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible
Maternity OB Visit	$10 copay for first visit, then 100%	20% after Deductible	$15 copay for first visit, then 100%	30% after Deductible	$15 copay for first visit, then 100%	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible
Emergency Medical Care									
Urgent Care	$10 copay	20% after Deductible	$15 Copay	30% after Deductible	$15 Copay	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible
Emergency Room (medical emergencies & accidents)	$25 copay	$25 copay	$50 copay	$50 copay	**$125 copay**	$125 copay	$35 Copay	20% after Deductible	20% after Deductible
Ambulance	10%	20% after Deductible	10%	30% after Deductible	10%	30% after Deductible	No Charge	20% after Deductible	40% after Deductible
Inpatient Hospital Care									
Inpatient Coverage including Mental Health Services	No Charge	20% after Deductible	No Charge	30% after Deductible	No Charge	30% after Deductible	No Charge	20% after Deductible	40% after Deductible
Other Services									
Durable Medical Equipment	10%	20% after Deductible	10%	30% after Deductible	10%	30% after Deductible	100% after $100 Ded	20% after Deductible	40% after Deductible
Pharmacy									
Maximum Out of Pocket**	$1,430 Indiv / $2,860 Family		$1,430 Indiv / $2,860 Family		$1,600 Indiv / $3,200 Family		$1,430 Indiv / $2,860 Family	Included in the In Ntwrk Medical Max Out of Pocket	
Retail (30 day supply)	$3 Generic / $10 Brand		$3 Generic / $10 Brand		**RETAIL (30day supply):** $5 Generic; $10 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*		$3 Generic / $10 Brand	20% after Deductible	
Mail Order (90 day supply)	$3 Generic / $10 Brand		$3 Generic / $10 Brand		**MAIL ORDER (90day supply):** $10 Generic; $20 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*		$3 Generic / $10 Brand	20% after Deductible	

Utilization Programs Required:

Mandatory Generic*

Step Therapy*

Closed Formulary*

*Policy allows clinical review to access desired medication at corresponding cost share

[1] Deductible is only durable medical equipment and appliances

*****Chiropractic, Acupuncture & Physical Therapy have a different fee schedule.**
Reimbursement will be capped as follows:
Chiropractic $35; Acupuncture $60; Physical Therapy $52

ILLUSTRATIVE ONLY
All Benefits Subject to Medical Necessity

4/14/2021