Jefferson Township Board of Education
Medical Plan Comparison
eff. 1/1/2023

	Aetna Open Access Managed Choice 10 (Open to employees hired prior to 7/1/20)		Aetna Open Access Managed Choice 15 (Open to employees hired prior to 7/1/20)		Aetna NJ Educators Health Plan (NJ EHP) (Open to all employees)		Aetna NJ Garden State Plan (NJ GSP) (Open to all employees)	
Monthly PREMIUM: Medical & Rx								
Single	$ 1,111.80		$ 1,062.91		$ 989.52		$ 916.87	
Parent/Child(ren)	$ 2,067.95		$ 1,977.03		$ 1,840.50		$ 1,705.37	
2 Adult	$ 2,223.61		$ 2,125.83		$ 1,979.04		$ 1,833.73	
Family	$ 3,179.76		$ 3,039.93		$ 2,830.02		$ 2,622.24	
	In-Network	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Service Areas	**Managed Choice POS (Open Access)**		**Managed Choice POS (Open Access)**		**Managed Choice POS (Open Access)**		**(NJ) Aetna Whole Health New Jersey Choice POS II [4]**	
Primary Care Physician (PCP) Referral Needed	**No**		**No**		**No**		**No**	
Annual Deductible								
Individual	$0	$100	$0	$100	$0	$350	$0	$350
Family	$0	$250	$0	$250	$0	$700	$0	$700
Coinsurance	100%; 90% on select services	80% of R&C[1]	100%; 90% on select services	70% of R&C[1]	100%; 90% on select services	70% of R&C [1]	100%; 90% on select services	70% of R&C [1]
Annual Out of Pocket Maximum (Includes Coinsurance, Copays, and Deductibles)								
Individual	$400	$2,000	$400	$2,000	$500	$2,000	$500	$2,000
Family	**$800**	$5,000	**$800**	$5,000	$1,000	$5,000	$1,000	$5,000
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Hospital Inpatient Services (room and board; physician visits)	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
Emergency Room	100% after $25 copay waived if admitted	100% after $25 copay waived if admitted	100% after $50 copay waived if admitted	100% after $50 copay waived if admitted	100% after $125 copay waived if admitted	100% after $125 copay waived if admitted	100% after $125 copay waived if admitted	100% after $125 copay waived if admitted
Ambulance	**90%; medically necessary non-emergency condition included**	**90%; medically necessary non-emergency condition included**	**90%; medically necessary non-emergency condition included**	**90%; medically necessary non-emergency condition included**	90%; non-emergency condition excluded	70% after deductible; non-emergency condition excluded	90%; non-emergency condition excluded	70% after deductible; non-emergency condition excluded
Radiation/Chemotherapy Outpatient	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
X-Ray and Lab Tests	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
Home Health Care	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
	Requires Pre-approval		Requires Pre-approval		Requires Pre-approval		Requires Pre-approval	
Skilled Nursing Facility	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
	120 days per calendar year combined		120 days per calendar year		120 days per calendar year combined		120 days per calendar year combined	
Private Duty Nursing (outpatient)	90%	80% after deductible	90%	70% after deductible	90%	70% after deductible	90%	70% after deductible
Hospice	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
	Requires Pre-approval		Requires Pre-approval		Requires Pre-approval		Requires Pre-approval	
Surgery/Anesthesia	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
Physician Office Visits [2]	$10 Copay (PCP) $10 Copay (Specialist)	80% after deductible	$15 Copay (PCP) $15 Copay (Specialist)	70% after deductible	$10 Copay (PCP) $15 Copay (Specialist)	70% after deductible	$10 Copay (PCP) $15 Copay (Specialist)	70% after deductible
Annual Physical Exams	100%	**80% after deductible**	100%	**70% after deductible**	100%	Not Covered	100%	Not Covered
Annual Well Child Care	100%	**80% after deductible**	100%	**70% after deductible**	100%	Not Covered	100%	Not Covered
Immunizations (except if travel or job related)	100%	**80% after deductible**	100%	**70% after deductible**	100%	Not Covered; Well Child immunizations: 70% after deductible (up to age 1)	100%	Not Covered; Well Child immunizations: 70% after deductible (up to age 1)
Annual OB-Gyn Exam	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
Annual Mammogram (baseline and women over age 40)	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
Annual Prostate screening (men over 50)	100%	**80% after deductible**	100%	**70% after deductible**	100%	Not Covered	100%	Not Covered

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	Aetna 10		Aetna 15		Aetna Educators Health Plan (EHP)		Aetna Garden State Health Plan (GSHP)	
	In-Network	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Maternity (including pre-natal)	$10 copay for 1st prenatal visit, then 100%	80% after deductible	$15 copay for 1st prenatal visit, then 100%	70% after deductible	$15 copay for 1st prenatal visit, then 100%	70% after deductible	$15 copay for 1st prenatal visit, then 100%	70% after deductible
Infertility services	$10 copay	80% after deductible	$15 copay	70% after deductible	$15 copay	70% after deductible	$15 copay	70% after deductible
	Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates	
Allergy Testing and Treatment	$10 copay	80% after deductible	$15 copay	70% after deductible	$15 copay	70% after deductible	$15 copay	70% after deductible
Acupuncture	$10 copay	80% after deductible, limited to $60/visit	$15 copay	70% after deductible, limited to $60/visit	$15 copay	70% after deductible, limited to $60/visit	$15 copay	70% after deductible, limited to $60/visit
Chiropractic Care	$10 copay	80% after deductible, limited to $35/visit	$15 copay	70% after deductible, limited to $35/visit	$15 copay	70% after deductible, limited to $35/visit	$15 copay	70% after deductible, limited to $35/visit
	30 visits per calendar year		30 visits per calendar year		30 visits per calendar year		30 visits per calendar year	
Short Term Therapies (Physical, Cognitive, Occupational, Respiratory, Speech)	$10 copay	80% after deductible, limited to $52/visit	$15 copay	70% after deductible, limited to $52/visit	$15 copay	70% after deductible, limited to $52/visit	$15 copay	70% after deductible, limited to $52/visit
	Unlimited		Unlimited		Unlimited		Unlimited	
Other Therapies (Chelation, dialysis, Infusion)	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
	Unlimited		Unlimited		Unlimited		Unlimited	
Hearing Aids	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
	One hearing aid for each impaired ear once in a 24-month period, only for members are 15 or younger		One hearing aid for each impaired ear once in a 24-month period, only for members are 15 or younger		One hearing aid for each impaired ear once in a 24-month period, only for members are 15 or younger		One hearing aid for each impaired ear once in a 24-month period, only for members are 15 or younger	
Durable Medical Equipment/Medical Supplies	90%	80% after deductible	90%	70% after deductible	90%	70% after deductible	90%	70% after deductible
Prosthetics and Orthotics	90%	80% after deductible	90%	70% after deductible	90%	70% after deductible	90%	70% after deductible
Inpatient Mental Illness/Substance Abuse/Alcohol Treatment [3]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Outpatient Mental Illness/Substance Abuse/Alcohol Treatment [3]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Routine Vision Exam	$10 copay (one annual exam/year)	**80% after deductible**	$15 copay (one annual exam/year)	**70% after deductible**	$15 copay (one annual exam/year)	Not Covered	$15 copay (one annual exam/year)	Not Covered
Vision Hardware	Not Covered		Not Covered		Not Covered		Not Covered	
Prescription Drug Benefit	10% Coinsurance Rx Out-of-Pocket Maximum In Network: $400 indiv./$800 family		10% Coinsurance Rx Out-of-Pocket Maximum In Network: $400 indiv./$800 family		Retail (30 day): $5 Generic/$10 Preferred Brand/Member pays difference Non-Preferred Brand Mail (90 day): $10 Generic/$20 Brand/Member pays difference Non-Preferred Brand Rx Out-of-Pocket Maximum: $1,600 indiv./$3,200 family		Retail (30 day): $5 Generic/$10 Preferred Brand/Member pays difference Non-Preferred Brand Mail (90 day): $10 Generic/$20 Brand/Member pays difference Non-Preferred Brand Rx Out-of-Pocket Maximum: $1,600 indiv./$3,200 family	
Child Dependent Termination age	Children covered to End of Year they turn age 26		Children covered to End of Year they turn age 26		Children covered to End of Year they turn age 26		Children covered to End of Year they turn age 26	

Comparison is for illustrative purposes only. Written plan documents will supersede any errors on this illustration.

1 Out-of-Network providers may bill you for difference between the carrier's Reasonable and Customary (R&C) limit and the provider's actual charges. This amount may be significant. It is important to note that all percentages for out-of-network services are percentages of the carrier's R&C, not the provider's actual charge. You are responsible for any charges in excess of R&C. R&C is 90th percentile of FAIR Health for OAMC $10 & OAMC $15 plans, and 200% CMS for NJ EHP & NJ GSP plans.

2 Copayments apply to in-network primary care and specialist office visits unless otherwise indicated

3 Mental health conditions and Alcohol/Substance Abuse treatment are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

4 NJ GSP plan is a NJ based network, representative of a smaller network with fewer in-network facilities/providers than other plan/network offerings. Out of state providers are excluded, unless true medical emergency.