Mount Laurel Township - Medical Benefits Overview - SNJ Fund/Aetna - Effective 2/1/2025

SNJ Fund/ Aetna Plan Name	Aetna Choice POS II $10 Open Access	Aetna Choice POS II $15 Open Access	Aetna Choice POS II $15/$25 Open Access	Aetna Choice POS II $20/$30 Open Access	Aetna Choice POS II $20/$35 Open Access
Replaces SHBP Plan	NJ Direct/Aetna Freedom 10	NJ Direct/Aetna Freedom 15	NJ Direct/Aetna Freedom 1525	NJ Direct/Aetna Freedom 2030	NJ Direct/Aetna Freedom 2035
IN-NETWORK (IN)					
Service Area Available	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide
Specialist Referral	No referral required	No referral required	No referral required	No referral required	No referral required
Deductible					
Individual	$0	$0	$0	$0	$200
Family	$0	$0	$0	$0	$500
Coinsurance	10%	10%	10%	10%	20% after deductible
Coinsurance Out-of-Pocket Maximum					
Individual	None	$400	$400	$800	$2,000
Family	None	$1,000	$1,000	$2,000	$5,000
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)					
Individual	$400	$7,360	$7,360	$7,360	$7,360
Family	$1,000	$14,720	$14,720	$14,720	$14,720
HEALTH CARE SERVICES					
Primary Care Office Visit	$10	$15	$15	$20	$20
Annual Routine Physical (In-Network Only)	$0	$0	$0	$0	$0
Direct Primary Care	$0	$0	$0	$0	$0
First Responders Doctors Office (FRDOCS)	$0	$0	$0	$0	$0
Telemedicine	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply
Specialist Office Visit	$10	$15	$25	$30/adult, $20/child	$35
Annual Routine Vision (In-Network Only)	$10	$15	$25	$30/adult, $20/child	$35
Chiropractic	$10	$15	$25	$30/adult, $20/child	$35
Physical/Occupational/Speech Therapy	$10	$15	$25	$30/adult, $20/child	$35 office visit/ 20% after deductible at an outpatient facility
DIAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING					
Outpatient Laboratory/Radiology/Advanced Imaging	$0	$0	$0	$0	20% after deductible
Freestanding Laboratory/Radiology/Advanced Imaging	$0	$0	$0	$0	20% after deductible
EMERGENCY/URGENT MEDICAL SERVICES					
Urgent Care Center	$10	$15	$25	$30/adult, $20/child	$35
Emergency Room	$75	$100	$100	$125	$300
Ambulance	10%	10%	10%	10%	20% after deductible
OTHER SERVICES					
Inpatient Facility	$0	$0	$0	$0	20% after deductible
Outpatient Facility	$0	$0	$0	$0	20% after deductible
Outpatient Behavioral Health	$10	$15	$25	$30/adult, $20/child	$35 office visit/
Durable Medical Equipment (DME)	10%	10%	10%	10%	20% after deductible
OUT-OF-NETWORK (OON)					
Deductible - Individual	$100	$100	$100	$200	$800
Deductible - Family	$250	$250	$250	$500	$2,000
Coinsurance after Deductible	20%	30%	30%	30%	40%
Out-of-Pocket Coinsurance Maximum - Individual	$2,000	$2,000	$2,000	$5,000	$6,500
Out-of-Pocket Coinsurance Maximum - Family	$5,000	$5,000	$5,000	$12,500	$13,000
Inpatient Hospital Deductible	$200/stay	$200/stay	$200/stay	$500/stay	$600/stay

-Preauthorization may be required for certain services.

-All plans with an out-of-network benefit have specified dollar limits for out-of-network chiropractic ($35), physical therapy ($52) and acupuncture ($60).

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Conner Strong and Buckelew
10.16.2024

Mount Laurel Township - Medical Benefits Overview - SNJ Fund/Aetna - Effective 2/1/2025

SNJ Fund/ Aetna Plan Name	Aetna HMO $10	Aetna Choice POS II $0	Aetna Choice POS II $100	Aetna Whole Health Plan	
Replaces SHBP Plan	**HORIZON HMO**	**NJ DIRECT** (employees hired prior to 7/1/19)	**NJ DIRECT2019** (new hires on or after 7/1/19)	**Omnia/Liberty Tier 1**	**Omnia/Liberty Tier 2**
IN-NETWORK (IN)					
Service Area Available	Nationwide Aetna HMO Network	Nationwide	Nationwide	NJ only	Nationwide
Specialist Referral	Referral required	No referral required	No referral required	No referral required	No referral required
Deductible					
Individual	See DME	$0	$100	$0	$1,500
Family	See DME	$0	n/a	$0	$3,000
Coinsurance	0%	10%	10% after deductible	0%	20% after deductible
Coinsurance Out-of-Pocket Maximum					
Individual	Not applicable	$800	$800	Not applicable	Not applicable
Family	Not applicable	$2,000	$2,000	Not applicable	Not applicable
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)					
Individual	$7,360	$7,360	$7,360	$2,500	$4,500
Family	$14,720	$14,720	$14,720	$5,000	$9,000
HEALTH CARE SERVICES					
Primary Care Office Visit	$10	$15	$15	$5	$20
Annual Routine Physical (In-Network Only)	$0	$0	$0	$0	$0
Direct Primary Care	Not available	$0	$0	$0	$0
First Responders Doctors Office (FRDOCS)	$0	$0	$0	$0	$0
Telemedicine	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply
Specialist Office Visit	$10	$15	$15	$15	$30
Annual Routine Vision (In-Network Only)	$10	$15	$15	$15	$30
Chiropractic	$10	$15	$15	$15	$30
Physical/Occupational/Speech Therapy	$10	$15	$15	$5 office visit/ $15 outpatient facility	$20 office visit/ 20% after deductible at an outpatient facility
DIAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING					
Outpatient Laboratory/Radiology/Advanced Imaging	$0	$0	$0	$15	20% after deductible
Freestanding Laboratory/Radiology/Advanced Imaging	$0	$0	$0	$0	$0
EMERGENCY/URGENT MEDICAL SERVICES					
Urgent Care Center	$10	$15	$15	$15	$30
Emergency Room	$85	$150	$150	$100	$100
Ambulance	$0	10%	10% after deductible	$0	$0
OTHER SERVICES					
Inpatient Facility	$0	$0	$0	$150 per admission	20% after deductible
Outpatient Facility	$0	$0	$0	$150	20% after deductible
Outpatient Behavioral Health	$10	$15	$15	$15	$30 office visit/ 20% after deductible at an outpatient facility
Durable Medical Equipment (DME)	$100 deductible, then covered in full	10%	10% after deductible	$0	$0
OUT-OF-NETWORK (OON)					
Deductible - Individual	No out-of-network benefits	$400	$400	No out-of-network benefits	No out-of-network benefits
Deductible - Family		$1,000	$1,000		
Coinsurance after Deductible		30%	30%		
Out-of-Pocket Coinsurance Maximum - Individual		$2,000	$2,000		
Out-of-Pocket Coinsurance Maximum - Family		$5,000	$5,000		
Inpatient Hospital Deductible		$500/stay	$500/stay		

-Preauthorization may be required for certain services.

-All plans with an out-of-network benefit have specified dollar limits for out-of-network chiropractic ($35), physical therapy ($52) and acupuncture ($60).

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Mount Laurel Township

Prescription Benefits Overview - SNJ Fund/Express Scripts - Effective 2/1/2025

SNJ Fund / Express Scripts	$3/$10/$10	$3/$10/$10	$7/$16/$35	$3/$18/$46	$7/$21/DIFF	$3/$10/$10	$7/$16/DIFF	$7/$16/$35
Corresponding SNJ Fund Medical Plan	Aetna Choice POS II $10	Aetna Choice POS II $15	Aetna Choice POS II $15/$25	Aetna Choice POS II $20/$30	Aetna Choice POS II $20/$35	Aetna HMO $10	Aetna Choice POS II $100	Aetna Whole Health
Replaces SHBP Plan	NJ Direct/Aetna Freedom 10	NJ Direct/Aetna Freedom15	NJ Direct/Aetna Freedom 1525	NJ Direct/Aetna Freedom 2030	NJ Direct/Aetna Freedom 2035	Horizon/Aetna HMO	NJ Direct/Direct 2019	OMNIA
Retail: Generic Copayments	$3	$3	$7	$3	$7	$3	$7	$7
Retail: Preferred Brand Copayments	$10	$10	$16	$18	$21	$10	$16	$16
Retail: Non-Preferred Brand Copayments	$10	$10	$35	$46	Member pays difference	$10	Member pays difference	$35
Retail: Brand w/ Generic Equivalent	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference
Mail: Generic Copayments	$0	$0	$0	$0	$0	$0	$0	$0
Mail: Preferred Brand Copayments	$15	$15	$40	$36	$52	$15	$40	$40
Mail: Non-Preferred Brand Copayments	$15	$15	$88	$92	Member pays difference	$15	Member pays difference	$88
Mail: Brand w/ Generic Equivalent	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference	Member pays difference
Prescription Drug annual Out-of-Pocket Maximum (Individual/Family)	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680	$1,840/$3,680

Member Pays Difference - You pay the cost difference between the brand drug and the generic drug.

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