Bellmawr School District 2020 - 2021 Plan Options

Rates Effective July 1, 2020 to June 30, 2021

Medical Coverage Selections - Schools Health Insurance Fund

Summary of Benefits	Aetna HMO 10 In Network	Aetna HMO 10 Out of Network	Aetna POS 15/25 In Network	Aetna POS 15/25 Out of Network
Deductible	$0 Individual	COVERED FOR EMERGENCY SERVICES ONLY	$0 Individual	$100 Individual
	$0 Family		$0 Family	$250 Family
Out of Pocket Limit	$5,300 Individual		$400 Individual	$2,000 Individual
	$10,600 Family		$1,000 Family	$5,000 Family
Primary Care	$10 copay		$15 copay	70% after deductible
Specialist	$10 copay		$25 copay	70% after deductible
Preventive	No Charge		No Charge	70% after deductible
Diagnostic (x-ray, blood work)	No Charge		No Charge	70% after deductible
Imaging (CT/PET scans, MRIs)	No Charge		No Charge	70% after deductible
Outpatient Surgery	No Charge		$200 Copay	70% after deductible
Emergency Room	$35 copay		$100 copay	$100 Copay
Emergency Transportation	No Charge		No Charge	No Charge
Urgent Care	$10 copay		$25 copay	70% after deductible
Hospital Stay	No Charge		No Charge	70% after deductible
	HMO 10 Monthly Rates		**POS 15/25 Monthly Rates**	
	Single $838.00		Single $833.00	
	Parent/Child(ren) $1,362.00		Parent/Child(ren) $1,366.00	
	Employee/Spouse $1,654.00		Employee/Spouse $1,657.00	
	Family $2,200.00		Family $2,200.00	

- **Preauthorization may be required for certain services.**
- **If you select the HMO plan, you must pick a Primary Care Physician. Referrals are also required to see a Specialist.**

Prescription Coverage - Express Scripts

Retail Copays (Up to 30 day Supply)	
Generic	$3 Copay
Preferred Brand	$10 Copay
Non-Preferred Brand	$10 Copay
Mail Order (Up to 90 day Supply)	
Generic	$5 Copay
Preferred Brand	$15 Copay
Non-Preferred Brand	$15 Copay

Prescription Monthly Rates

Single $210.00
Parent/Child(ren) $347.00
Employee/Spouse $421.00
Family $557.00

***Refer to the carrier plan documents for full coverage**

Delta Dental Premier Plan

Preventive & Diagnostic - Covered 100%
(exams, cleanings, x-rays)
Basic Services - Covered 70% after deductible
(Fillings, extractions, endodontics, periodontics, sealants)
Crowns & Prosthodontics - Covered 50% after deductible
(crowns, bridgework, repairs, dentures, inlays)
Calendar Year Maximum - $1,500.00
Calendar Year Deductible $50 Individual / $150 Family
Orthodontia (Dependent Children Only)
Maximum (Lifetime) $1,500.00

Dental Monthly Rates

Single $68.00
Employee + One $68.00
Employee + Two $68.00

VSP Vision Plan

Exam - $25 Copay / Once every 12 months
Frames - $130 allowance / once every 24 months
Lenses -Single vision, lined bifocal, & lined trifocal every 24 months; combined with exam

Contact Lenses (instead of frames) - $130 allowance every 24 months, $60 copay
Lens Enhancements Savings
Laser Vision Correction Discounts

VSP Monthly Rates

Single - $7.10
Employee + One - $10.30

Need Help With Your Benefits or Have a Benefits Question?

Contact the Member Advocacy Team at 800.563.9929 or cssteam@connerstrong.com

*This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical, prescription, dental, and vision programs. Some plan limitations may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.