

Bellmawr Board of Education - 2020 Medical Plan Options

BENEFIT	Aetna HMO		Aetna POS \$15/\$25 Monthly Rates	
	In Network Only		In Network	Out of Network
Deductible	\$0 Ind/\$0 Fam	OUT OF NETWORK - COVERED FOR EMERGENCY SERVICES ONLY	\$0 Ind/\$0 Fam	\$100 Ind/\$250 Fam
Out of Pocket Limit	\$5,300 Ind/\$10,600 Fam		\$400 Ind/\$1,000 Fam	\$2,000 Ind/\$5,000 Fam
Primary Care	\$10 Copay		\$15 Copay	70% After Deductible
Specialist	\$10 Copay		\$25 Copay	70% After Deductible
Chiropractic Care	\$10 Copay (20 visits/calendar year)		\$25 Copay (30 visits/calendar year)	70% After Deductible
Preventive Care	Covered 100%		Covered 100%	70% After Deductible
Diagnostic (x-ray, blood work)	Covered 100%		Covered 100%	70% After Deductible
Imaging (CT/PET scans, MRIs)	Covered 100%		Covered 100%	70% After Deductible
Outpatient Surgery Facility Fee/Physician/Surgeon Fees	Covered 100%		\$200 Copay	70% After Deductible
Emergency Room	\$35 Copay No Coverage For Non-Emergency		\$100 Copay No Coverage For Non-Emergency	
ER Transportation	Covered 100% No Coverage For Non-Emergency		Covered 100% No Coverage For Non-Emergency	
Urgent Care	\$10 Copay		\$25 Copay	70% After Deductible
Hospital Stay Facility Fee/Physician/Surgeon	Covered 100%		Covered 100%	70% After Deductible
Mental/Behavioral Health Outpatient Substance Abuse Outpatient	\$10 Copay for Mental Health Covered 100% for Substance Abuse		\$25 Copay for Mental Health Covered 100% for Substance Abuse	70% After Deductible
Mental/Behavioral Health Inpatient Substance Abuse Inpatient	Covered 100%		Covered 100%	70% After Deductible
Maternity Prenatal/Postnatal Care Delivery & Inpatient Services	\$10 Copay for Professional Services Covered 100%		\$25 Copay for First Office Visit Covered 100%	70% After Deductible
Home Health Care	Covered 100%		Covered 100%	70% After Deductible
Rehabilitation Services	\$10 Copay		\$25 Copay	70% After Deductible
Habilitation Services	\$10 Copay		\$25 Copay	70% After Deductible
Skilled Nursing Care	Covered 100% (Limited to 120 Days)		Covered 100% (Limited to 120 Days)	70% After Deductible (Limited to 60 Days)
Durable Medical Equipment	Plan Pays 100% after \$100 Deductible		10% Coinsurance	70% After Deductible
Hospice Service	Covered 100%		Covered 100%	70% After Deductible
Eye Exam (1 routine exam/12 month)	\$10 Copay		\$25 Copay	Not Covered
Medical Monthly Rates -7/1/19 to 6/30/20	Aetna HMO \$10 Monthly Rates		Aetna POS \$15/\$25 Monthly Rates	
Single	\$763		\$758	
Parent/Child(ren)	\$1,240		\$1,244	
Employee / Spouse	\$1,506		\$1,509	
Family	\$2,003		\$2,003	

Preauthorization may be required for certain services.

PLEASE NOTE- This overview is being provided for informational purposes only and does not contain all the terms, conditions, exclusions and limitations of the insurance carrier's policy. Complete details of your program appear in the policy provided by the carrier, which govern the benefits and operation of your program. The policy supersedes if there should be any inconsistency or difference between its provisions and the information in this overview.