Gloucester City School District

SHIF - Benefit Comparison

	EHP (Educators Health Plan)		AETNA Choice POS II $ 10		AETNA Choice POS II $ 15		AETNA Choice POS II $ 20/ $ 30		AETNA Choice POS II $ 20/ $ 35	
	In-Network	*Out-of-Network	In-Network	Out-of-Network	In-Network	Out -of-Network	In-Network	Out -of-Network	In-Network	Out -of-Network
Benefit Period	Calendar Year		Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Out of Network Reimbursement	200% of CMS		90th FAIR Health		90th FAIR Health		90th FAIR Health		90th FAIR Health	
Annual Deductible Individual Family	$0 $0	$350 $700	$0 $0	$100 $250	$0 $0	$100 $250	$0 $0	$200 $500	$200 $400	$800 $2,000
Coinsurance	10% (on selected services)	30%	10% (on selected services)	20%	10% (on selected services)	30%	10% (on selected services)	30%	20%	40%
Out of Pocket Maximum Individual Family	$500 $1,000	$2,000 $5,000	$400 $800	$2,000 $5,000	$400 $800	$2,000 $5,000	$800 $1,600	$5,000 $12,000	$2,000 $4,000	$6,500 $13,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Office Visit	$10	30% after deductible	$10	20% after deductible	$15	30% after deductible	$20	30% after deductible	$20	40% after deductible
Specialist Office Visit	$15	30% after deductible	$10	20% after deductible	$15	30% after deductible	$30	30% after deductible	$35	40% after deductible
Preventative Care For Adults and Children	100% (no copayment)	30% after deductible	100% (no copayment)	20% after deductible	100% (no copayment)	30% after deductible	100% (no copayment)	30% after deductible	100% (no copayment)	40% after deductible
Emergency Room	$125	$125	$25	$25	$50	$50	$100	$100	$100	$100
Urgent Care Center	$15	30% after deductible	$10	20% after deductible	$15	30% after deductible	$30	30% after deductible	$35	40% after deductible
Ambulance Services	10%	30% after deductible	10%	20% after deductible	10%	30% after deductible	10%	30% after deductible	20% after deductible	40% after deductible
Chiropractic Service	$15	$35 dollar capped reimbursement per date of service after deductible	$10	20% after deductible	$15	30% after deductible	$25	30% after deductible	$25	40% after deductible
	30 visit max, per calendar year, combined in and out of network		***30 visit max, per calendar year, combined in and out of network***		***30 visit max, per calendar year, combined in and out of network***		***30 visit max, per calendar year, combined in and out of network***		***30 visit max, per calendar year, combined in and out of network***	
Physical Therapy	$15	$52 dollar capped reimbursement per date of service after deductible	$10	20% after deductible	$15	30% after deductible	$30	30% after deductible	$35	40% after deductible
Acupuncture	$15	$60 dollar capped reimbursement per date of service after deductible	$10	20% after deductible	$15	30% after deductible	$30	30% after deductible	$35	40% after deductible
Durable Medical Equipment	10%	30% after deductible	10%	20% after deductible	10%	30% after deductible	10%	30% after deductible	20% after deductible	40% after deductible
Prescription Drug Benefit										
Retail Copay	$5/$10		$3/$10		$3/$10		$7/$21		$7/$21	
Mail Order Copay-up to 90 day supply	$10/$20		$5/$15		$5/$15		$18/$52		$18/$52	
Out of Pocket Maximum	$1600/$3200		$1580/$3160		$1580/$3160		$1580/$3160		$1580/$3160	
Mandatory Generic	Yes		No		No		No		No	

Comparison is for illustrative purposes only. Written plan document supersedes any errors on this illustration.

***out of network reimbursement is set at 200% of CMS for the EHP**

Out-of-network providers may bill you for differences between the R&C, which is the amount paid by carrier, and the provider's actual charge. This amount may be significant. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

Gloucester City School District

SHIF - AETNA Benefit Comparison

	AETNA HMO $10	AETNA HMO $15/$25	AETNA HMO $20/$30	AETNA HMO $20/$35
	In-Network Only	**In-Network Only**	**In-Network Only**	**In-Network Only**
Benefit Period	**Calendar Year**	**Calendar Year**	**Calendar Year**	**Calendar Year**
Out of Network Reimbursement	**N/a**	**N/a**	**N/a**	**N/a**
Annual Deductible				
Individual	$0	$0	$0	$200
Family	$0	$0	$0	$400
Coinsurance	0%	0%	10% (on selected services)	20%
Out of Pocket Maximum				
Individual	$5,880	$6,320	$6,320	$6,320
Family	$11,760	$12,640	$12,640	$12,640
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Office Visit	$10	$15	$20	$20
Specialist Office Visit	$10	$25	$30	$35
Preventative Care For Adults and Children	100% (no copayment)	100% (no copayment)	100% (no copayment)	100% (no copayment)
Emergency Room	$35	$75	$100	$100
Urgent Care Center	$10	$25	$30	$35
Ambulance Services	100% Paid	100% Paid	10%	20% after deductible
Chiropractic Service	$10 ***30 visit max, per calendar***	$25 ***30 visit max, per calendar year***	$30 ***30 visit max, per calendar year***	$35 ***30 visit max, per calendar***
Physical Therapy	$10	$25	$30	$35
Acupuncture	$10	$25	$30	$35
Durable Medical Equipment	100% Paid	100% Paid	10%	20% after deductible
Prescription Drug Benefit				
Retail Copay	$3/$10	$7/$16/$35	$7/$16/$35	$7/$16/$35
Mail Order Copay-up to 90 day supply	$5/$15	$18/$40/$88	$18/$40/$88	$18/$40/$88
Out of Pocket Maximum	$1580/$3160	$1580/$3160	$1580/$3160	$1580/$3160
Mandatory Generic	No	No	No	No

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