Mercer County Special Services School District Plan Options

Carrier Change from Horizon to Aetna 1/1/2027

	AETNA NJ Educators Health Plan		AETNA Garden State Plan* NJ Provider and Facilities Only		AETNA Open Access $10		AETNA Open Access $15	
	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Deductibles								
Individual	N/A	$350	N/A	$350	N/A	$100	N/A	$100
Family	N/A	$700	N/A	$700	N/A	$250	N/A	$250
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out of Pocket Limit* **								
Individual	$500	$2,000	$500	$2,000	$400	$2,000	$400	$2,000
Family	$1,000	$5,000	$1,000	$5,000	$800	$5,000	$800	$5,000
Primary Care Physician Selection	Not Required	Not Applicable	Not Required	Not Applicable	Not Required	Not Applicable	Not Required	Not Applicable
Preventive Care								
Routine Adult Physician Exams/Immunizations	No charge	30% no deductible	No charge	30% no deductible	No charge	20% (no deductible)	No charge	30% (no deductible)
Routine Well Child Exams/Immunizations	No charge	30% no deductible	No charge	30% no deductible	No charge	20% (no deductible)	No charge	30% (no deductible)
Routine Gynecological Care Exams	No charge	30% no deductible	No charge	30% no deductible	No charge	20% (no deductible)	No charge	30% (no deductible)
Routine Mammograms	No charge	30% no deductible	No charge	30% no deductible	No charge	20% (no deductible)	No charge	30% (no deductible)
Physician's Office Visit								
Primary Care Services	$10 copay	30% after deductible	$10 copay	30% after deductible	$10 copay	20% after deductible	$15 copay	30% after deductible
After Office Hours/Home	$10 copay	30% after deductible	$10 copay	30% after deductible	$10 copay	20% after deductible	$15 copay	30% after deductible
Specialist Services	$15 copay	30% after deductible	$15 copay	30% after deductible	$10 copay	20% after deductible	$15 copay	30% after deductible
Maternity OB Visit	$15 copay - 1st visit only	30% after deductible	$15 copay - 1st visit only	30% after deductible	$10 copay - 1st visit only	20% after deductible	$15 copay - 1st visit only	30% after deductible
Outpatient Diagnostic Procedures								
Diagnostic Laboratory	No charge	30% after deductible	No charge	30% after deductible	No charge	20% after deductible	No charge	30% after deductible
Diagnostic X-ray	No charge	30% after deductible	No charge	30% after deductible	No charge	20% after deductible	No charge	30% after deductible
Emergency Medical Care								
Urgent Care	$15 copay	30% after deductible	$15 copay	30% after deductible	$10 copay	20% after deductible	$15 Copay	30% after deductible
Emergency Room	$125 copay	30% after deductible	$125 copay	30% after deductible	$25 copay	$25 copay	$50 copay	$50 copay
Ambulance	10% after deductible	30% after deductible	10% after deductible	30% after deductible	90%	20% after deductible	10%	30% after deductible
Hospital Care								
Inpatient Coverage	No charge	30% after deductible	No charge	30% after deductible	No charge	20% after deductible and $200 copay	No charge	30% after deductible
Outpatient Surgery	No charge	30% after deductible	No charge	30% after deductible	No charge	20% after deductible	No charge	30% after deductible
Vision								
Eye Exam	$15 copay	Not Covered	$15 copay	Not Covered	$10 copay	Not Covered	$15 copay	Not Covered
Hardware	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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Mental Health Services **Alcohol/Drug Abuse Services**	Same as any other illness; benefit depends on place of service		Same as any other illness; benefit depends on place of service		Same as any other illness; benefit depends on place of service		Same as any other illness; benefit depends on place of service	
Other Services								
Prosthetics	10% after deductible	30% after deductible	10% after deductible	30% after deductible	$10 copay	20% after deductible	$15 copay	30% after deductible
Orthotics	10% after deductible	30% after deductible	10% after deductible	30% after deductible	$10 copay	20% after deductible	$15 copay	30% after deductible
Durable Medical Equipment	10% after deductible	30% after deductible	10% after deductible	30% after deductible	10%	20% after deductible	10%	30% after deductible
Skilled Nursing Facility	No charge 120 Days per calendar year	30% after deductible 60 days per calendar year	No charge 120 Days per calendar year	30% after deductible 60 days per calendar year	No charge 120 Days per combined in and out of network	20% after deductible	No charge 120 Days combined in and out of network	30% after deductible
Outpatient Rehabilitation Therapy (includes speech, physical, and occupational therapy)	$15 copay	30% after deductible	$15 copay	30% after deductible	$10 copay	20% after deductible	$15 copay	30% after deductible
Chiropractic Care	$15 copay	30% after deductible	$15 copay	30% after deductible	$10 copay	20% after deductible	$15 copay	30% after deductible
Prescription (Through Benecard)								
Generic - Retail (30 day limit) / Mail Order (90 day limit)	$5 Copay Retail /$10 Copay Mail Order****		$5 Copay Retail /$10 Copay Mail Order****		$10 Copay Retail /$15 Copay Mail Order****		$10 Copay Retail /$15 Copay Mail Order****	
Brand Name - Retail (30 day limit / Mail Order (90 day limit)	$10 Copay Retail / $20 Copay Mail Order*****		$10 Copay Retail / $20 Copay Mail Order*****		$5 Copay Retail / $5 Copay Mail Order*****		$5 Copay Retail / $5 Copay Mail Order*****	

**Garden State Plan offers a similar plan design as the NJ Educators Plan, but limits access to New Jersey Providers ONLY through the Aetna Network. With the exception of a TRUE medical emergency care, this plan does not cover any service that takes place outside of the state of New Jersey*

***All out of network services subject to deductible unless otherwise stated*

****In Network Copays, Coinsurance and Deductibles build towards the out of pocket maximum*

**** Mandatory Generic Program - Pharmacist must discpense the generic equivalent drug when one is available

***** Step Therapy - Member must use the most cost effective, clically effective preferred treatment prior to progessing to alternative therapies

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract.