

**SHAMONG TOWNSHIP BOARD OF EDUCATION COMPARISON
AETNA CHOICE POS II \$15 vs. HORIZON DIRECT ACCESS \$15**

	Aetna Choice POS II \$15		Horizon Direct Access \$15	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital In-patient	100%	70% after deductible	100%	70% after deductible
Skilled Nursing Facility	100% 120 days per cal. Year	70% after deductible 60 days per cal. Year	100% 120 days per cal. Year	70% after deductible 60 days per cal. Year
Hospital Pre-Admission Testing	100%	70% after deductible	100%	70% after deductible
Physician (Surgery)	100%	70% after deductible	100%	70% after deductible
Primary Care (Office Visits)	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible
Specialist (Office Visits)	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible
Chiropractic	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible
	30 visits per calendar year		30 visits per calendar year	

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Emergency Room	100% after \$50 copay		100% after \$50 copay	
Durable Medical Equipment	90%	70% after deductible	90%	70% after deductible
Radiation/ Chemotherapy Outpatient	100%	70% after deductible	100%	70% after deductible
Well-Child Immunizations	100%	70% no deductible	100%	70% no deductible
Adult Immunizations	100%	70% no deductible	100%	70% no deductible
Routine Adult Physical Exams	100%	70% no deductible	100%	70% no deductible
Routine OB/GYN Exam	100%	70% no deductible	100%	70% no deductible
Routine Eye Exam	100% after \$15 copay	Not Covered	100% after \$15 copay	Not Covered

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Imaging Tests (MRIs, MRAs, CAT & PET Scans)	100%	70% after deductible	100%	70% after deductible
X-Rays/Lab Tests	100%	70% after deductible	100%	70% after deductible
Maternity (Physician)	100% after \$15 copay for initial visit	70% after deductible	100% after \$15 copay for initial visit	70% after deductible
Well Child Care	100%	70% no deductible	100%	70% no deductible
Alcohol Abuse (Outpatient)	100%	70% after deductible	100%	70% after deductible
Alcohol Abuse (In-patient)	100%	70% after deductible	100%	70% after deductible
Mental Health (In-patient)	100%	70% after deductible	100%	70% after deductible

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Mental Health (Office visit)	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible
Physical/Speech/ Occupational Therapy	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible
Ambulance	90%	70% after deductible	90%	70% after deductible
Acupuncture	100%	70% after deductible	100%	70% after deductible
Diabetes Supplies	90%	70% after deductible	90%	70% after deductible
Deductibles (Individual)	N/A	\$150	N/A	\$150
Deductibles (Family Maximum)	N/A	\$250	N/A	\$250
Maximum Out-of-Pocket (Individual)	\$400	\$2,000	\$400	\$2,000

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Maximum Out-of-Pocket (Family)	\$800	\$5,000	\$800	\$5,000
Annual/Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited