SHAMONG TOWNSHIP BOARD OF EDUCATION
AETNA QPOS $10 vs. HORIZON POS $10

	Aetna QPOS $10		Horizon POS $10	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Service Area	Unrestricted	Unrestricted	Restricted	Unrestricted
PCP Selection/Referral Requirement	Yes	No	Yes	No
Hospital In-patient	100%	60% after deductible	100%	60% after deductible
Skilled Nursing Facility	100%	60% after deductible	100%	60%/after deductible
	120 days per calendar year	60 days per calendar year	120 days per calendar year	60 days per calendar year
Hospital Pre-Admission Testing	100%	100%	100%	100%
Physician (Surgery)	100%	60% after deductible	100%	60% after deductible
Primary Care (Office Visits)	100% after $10 copay	60% after deductible	100% after $10 copay	60% after deductible
Specialist (Office Visits)	100% after $10 copay	60% after deductible	100% after $10 copay	60% after deductible
Chiropractic	100% after $10 copay	60% after deductible	100% after $10 copay	60% after deductible
	25 visits per calendar year		25 visits per calendar year	
Emergency Room	100% after $35 copay		100% after $35 copay	

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	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Durable Medical Equipment	100%	60% after deductible	100%	60% after deductible
Well-Child Immunizations	100%	60% no deductible	100%	60% no deductible
Routine Adult Physical Exams	100%	60% no deductible	100%	60% no deductible
X-Rays/Lab Tests	100%	60% after deductible	100%	60% after deductible
Maternity (Physician)	100%, after $10 copay for initial visit	60% after deductible	100%, after $10 copay for initial visit	60% after deductible
Well Child Care	100%	60% no deductible	100%	60% no deductible
Alcohol Abuse (Outpatient)	100%	60% after deductible	100%	60% after deductible
Alcohol Abuse (In-patient)	100%	60% after deductible	100%	60% after deductible
Mental Health (Inpatient)	100%	60% after deductible	100%	60% after deductible

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	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health/Alcohol Abuse (Office visit)	100% after $10 copay	60% after deductible	100% after $10 copay	60% after deductible
Physical/Speech Therapy	100% after $10 copay	60% after deductible	100% after $10 copay	60% after deductible
	60 visits per calendar year		60 visits per calendar year	
Ambulance	100%	60% after deductible	100%	60% after deductible
Foot Orthotics	100% after $10 copay	60% after deductible	100% after $10 copay	60% after deductible
Oxygen & Administration	100%	60% after deductible	100%	60% after deductible
Diabetes Supplies	100%	60% after deductible	100%	60% after deductible
Home Health Care	100%	60% after deductible 100 visit maximum	100%	60% after deductible 100 visit maximum
Hospice	100%	60% after deductible	100%	60% after deductible

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	Aetna QPOS $10		Horizon POS $10	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductibles (Individual)	None	$500	None	$500
Deductibles (Family Maximum)	None	$1,000	None	$1,000
Maximum Out-of-Pocket (Individual)	$4,000		$4,000	
Maximum Out-of-Pocket (Family)	$8,000		$8,000	
Maximum Plan Covered Expenses Annual/Lifetime	Unlimited		Unlimited	