Arthur J. Gallagher & Co.

Benefits Provided By:

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1-(800)-872-3862

Randolph Township Board of Education
2024-2025

	SHIF Aetna Managed Choice POS $5		SHIF Aetna Managed Choice POS $25		SHIF Aetna Open Access EC Savings Plus		SHIF Aetna Open Access Managed Choice HSA w/ Rx		SHIF Aetna New Jersey Educators Health Plan		SHIF Aetna Garden State Health Plan *NJ Providers Only	
BENEFIT	**IN-NETWORK**	**OUT OF NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**Maximum Savings (Tier 1)**	**Standard Savings (Tier 2)**	**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		Calendar Year	
Deductible Individual	$0	$100	$500	$3,000	$0	$1,500	$1,500		$0	$350	$0	$350
Deductible Family	$0	$250	$1,000	$6,000	$0	$3,000	$3,000 **True Family Deductible*		$0	$700	$0	$700
Coinsurance	100%	70%	90%	70%	100%	100%	100%	70%	100%	70%	100%	70%
Maximum Out of Pocket Individual	$400	$2,000	$5,000	$6,000	$400	$2,000	$5,000	$10,000	$500	$2,000	$500	$2,000
Maximum Out of Pocket Family	$800	$5,000	$10,000	$12,000	$800	$4,000	$10,000	$20,000	$1,000	$5,000	$1,000	$5,000
Out of Network Fee Schedule	N/A	180% of CMS	N/A	180% of CMS	N/A	180% of CMS	N/A	180% of CMS	N/A	200% of CMS	N/A	200% of CMS
Primary Care Physician	Required		Required		Not Required		Not Required		Not Required		Not Required	
Specialist Referral	Required		Required		Not Required		Not Required		Not Required		Not Required	
Primary Care Office Visit	$5 Copay	70% after deductible	$25 Copay	70% after deductible	$5 Copay	$10 Copay	100% after deductible	70% after deductible	$10 Copay	70% after deductible	$10 Copay	70% after deductible
Specialist Office Visit	$5 Copay	70% after deductible	$35 Copay	70% after deductible	$5 Copay	$10 Copay	100% after deductible	70% after deductible	$15 Copay	70% after deductible	$15 Copay	70% after deductible
Maternity Visits	$5 Copay **Copay applies to 1st visit only*	70% after deductible	$35 Copay **Copay applies to 1st visit only*	70% after deductible	$5 Copay **Copay applies to 1st visit only*	$10 Copay **Copay applies to 1st visit only*	100% after deductible	70% after deductible	$15 Copay **Copay applies to 1st visit only*	70% after deductible	$15 Copay **Copay applies to 1st visit only*	70% after deductible
Allergy Testing and Treatment	100%	70% after deductible	100%	70% after deductible	100%	100% (no deductible)	100%	70% after deductible	100%	70% (no deductible)	100%	70% (no deductible)
Routine Physical	100%	70% (no deductible)	100%	70% (no deductible)	100%	100% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)
Annual Routine OBGYN Exam	100%	70% (no deductible)	100%	70% (no deductible)	100%	100% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)
Routine PAP/Mammograms	100%	70% (no deductible)	100%	70% (no deductible)	100%	100% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)
Prostate/Colorectal Screening	100%	70% (no deductible)	100%	70% (no deductible)	100%	100% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)
Immunizations	100%	70% (no deductible)	100%	70% (no deductible)	100%	100% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)
Well Child Care	100%	70% (no deductible)	100%	70% (no deductible)	100%	100% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)
Laboratory	100%	70% after deductible	100% (no deductible)	70% after deductible	100%	100% (no deductible)	100% after deductible	70% after deductible	100%	70% (no deductible)	100%	70% (no deductible)
Radiology Services*	100%	70% after deductible	100% (no deductible)	70% after deductible	100%	100% (no deductible)	100% after deductible	70% after deductible	100%	70% (no deductible)	100%	70% (no deductible)
Inpatient Hospital	100%	70% after deductible	90% after deductible	70% after deductible	100%	100% (no deductible)	100% after deductible	70% after deductible	100%	70% (no deductible)	100%	70% (no deductible)
Emergency Room	100% after $25 Copay		100% after $100 Copay		100% after $25 Copay		100% after deductible		100% after $125 Copay		100% after $125 Copay	

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Ambulance	100%		100% (no deductible)		100%		100% after deductible		90%	70% after deductible	90%	70% after deductible
Outpatient Surgery	100%	70% after deductible	90% after deductible	70% after deductible	100%	100% after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Ambulatory SurgiCenter	100%	70% after deductible	90% after deductible	70% after deductible	100%	100% after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Mental Health Inpatient	100%	70% after deductible	90% after deductible	70% after deductible	100%	$150 per confinement copay after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Mental Health/Out Patient	100%	70% after deductible	90% (no deductible)	70% after deductible	100%	100% after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Mental Health Office Setting	$5 Copay	70% after deductible	$35 Copay	70% after deductible	$5 Copay	$10 Copay	100% after deductible	70% after deductible	100% after $15 Copay	70% after deductible	100% after $15 Copay	70% after deductible
Substance Abuse Inpatient	100%	70% after deductible	90% after deductible	70% after deductible	100%	$150 per confinement copay after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Substance Abuse/Out Patient	100%	70% after deductible	90% (no deductible)	70% after deductible	100%	100% after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Substance Abuse Office Setting	$5 Copay	70% after deductible	$35 Copay	70% after deductible	$5 Copay	$10 Copay	100% after deductible	70% after deductible	100% after $15 Copay	70% after deductible	100% after $15 Copay	70% after deductible
Alcohol Abuse Inpatient	100%	70% after deductible	90% after deductible	70% after deductible	100%	$150 per confinement copay after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Alcohol Abuse Outpatient	100%	70% after deductible	90% (no deductible)	70% after deductible	100%	100% after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Alcohol Abuse Office	$5 Copay	70% after deductible	$35 Copay	70% after deductible	$5 Copay	$10 Copay	100% after deductible	70% after deductible	100% after $15 Copay	70% after deductible	100% after $15 Copay	70% after deductible
Acupuncture	100%	70% after deductible	100% after office copay	70% after deductible	100% after $5 Copay	100% after $10 Copay	N/A	N/A	100% after $15 Copay *Unlimited	70% after deductible *Unlimited *MAX allowoance per visit up to $60	100% after $15 Copay *Unlimited	70% after deductible *Unlimited *MAX allowoance per visit up to $60
Bariatric Surgery	100%	70% after deductible	90% after deductible	70% after deductible	100%	100% (no deductible)	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Diabetic Education	100%	70% after deductible	90% after deductible	70% after deductible	100%	100% after deductible	100% after deductible	70% after deductible	100% after $15 Copay	70% after deductible	100% after $15 Copay	70% after deductible
Diabetic Supplies	100%	70% after deductible	90% after deductible	70% after deductible	100%	100% after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Durable Medical Equipment	100%	70% after deductible	50% after deductible	50% after deductible	100%	100% (no deductible)	100% after deductible	70% after deductible	90%	70% after deductible	90%	70% after deductible

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Home Health Care	100%	70% after deductible	90% after deductible	70% after deductible	100% *Limited to 60 visits per year	100% after deductible *Limited to 60 visits per year	100% after deductible *Limited to 100 visits per year	70% after deductible *Limited to 60 days per year	100%	70% after deductible	100%	70% after deductible
Hospice Care	100%	70% after deductible	90% after deductible	70% after deductible	100%	100% after deductible	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Infertility	100%	70% after deductible	90% after deductible	70% after deductible	100%	100% after deductible	100% after deductible	70% after deductible	100% after $15 Copay *Limited to 4 egg retrievals per lifetime	70% after deductible *Limited to 4 egg retrievals per lifetime	100% after $15 Copay *Limited to 4 egg retrievals per lifetime	70% after deductible *Limited to 4 egg retrievals per lifetime
Nutritional Counseling	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100% after $15	70% after deductible	100% after $15	70% after deductible
Orthotics/ Prosthetics	$5 Copay	70% after deductible	$25 Copay	70% after deductible	$5 Copay	$10 Copay (no deductible)	100% after deductible	70% after deductible	100% after $15 Copay	70% after deductible	100% after $15 Copay	70% after deductible
Physical Rehabilitation- Inpatient	100%	70% after deductible	$20 Copay	70% after deductible	$5 Copay	$20 Copay	100% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible
Private Duty Nursing	100%	70% after deductible	90% after deductible *Limited to 30 visits per year	70% after deductible *Limited to 30 visits per year	100% *Limited to 30 visits per year	100% after deductible *Limited to 30 visits per year	100% after deductible *Limited to 3 visits per year	70% after deductible *Limited to 3 visits per year	90% *Unlimited	70% after deductible *Unlimited	90% *Unlimited	70% after deductible *Unlimited
Physical Therapy	$5 Copay	70% after deductible	$20 Copay *60 visits per year	70% after deductible *60 visits per year	$5 Copay	$20 Copay	100% after deductible *Limited to 60 visits per year	70% after deductible *Limited to 60 visits per year	100% after $15 Copay *Unlimited	70% after deductible *Unlimited *MAX allowance per visit up to $52	100% after $15 Copay *Unlimited	70% after deductible *Unlimited *MAX allowance per visit up to $52
Short Term Therapy: Occupational, Speech, Respiratory	$5 Copay	70% after deductible	$20 Copay *30 visits per year Speech, 60 visits Occupational	70% after deductible *30 visits per year Speech, 60 visits Occupational	$5 Copay *Limited to 30 visits speech, 60 visits physical & occupational	$20 Copay *Limited to 30 visits speech, 60 visits physical & occupational	100% after deductible *Limited to 30 visits speech, 60 visits occupational	70% after deductible *Limited to 30 visits speech, 60 visits occupational	100% after $15 Copay	70% after deductible	100% after $15 Copay	70% after deductible
Skilled Nursing Facility	100% *Limited to 100 days per year	70% after deductible *Limited to 60 days per year	90% after deductible *Limited to 100 days per year	70% after deductible *Limited to 60 days per year	100% *Limited to 60 days per year	$150 per confinement copay after deductible *Limited to 60 days per year	100% after deductible *Limited to 100 days per year	70% after deductible *Limited to 60 days per year	100% up to 120 days *120 days Combined In & OON	70% after deductible up to 60 days *120 days Combined In & OON	100% up to 120 days *120 days Combined In & OON	70% after deductible up to 60 days *120 days Combined In & OON
Therapeutic Manipulation (Chiropractic)	$5 Copay	70% after deductible	$25 Copay *Limited to 20 visits per year	70% after deductible *Limited to 20 visits per year	$5 Copay *Limited to 25 visits per year	$10 Copay *Limited to 25 visits per year	100% after deductible *Limited to 20 visits per year	70% after deductible *Limited to 20 visits per year	100% after office copay *30 visit MAX per benefit period	70% after deductible *30 visit MAX per benefit period *MAX allowance per visit up to $35	100% after office copay *30 visit MAX per benefit period	70% after deductible *30 visit MAX per benefit period *MAX allowance per visit up to $35
Vision- Routine Eye Exam	$5 Copay *1 per Calendar Year	70% after deductible *1 per Calendar Year	$35 Copay *1 per Calendar Year	70% after deductible *1 per Calendar Year	$5 Copay *1 per Calendar Year	$10 Copay (no deductible) *1 per Calendar Year	100% (no deductible) *1 per Calendar Year	70% (no deductible) *1 per Calendar Year	100% after $15 Copay	Not Covered	100% after $15 Copay	Not Covered
Vision Hardware (Glasses/Contacts)	$100 every 12 months		$100 every 24 months		$150 every 12 months		Not Covered		Not Covered		Not Covered	

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Telemedicine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100% after $15 Copay	Not Covered	100% after $15 Copay	Not Covered
Prescription Plan - Express Scripts	**Retail**	**Mail Order**	**Retail**	**Mail Order**	**Retail**	**Mail Order**	**Retail**	**Mail Order**	**Retail**	**Mail Order**	**Retail**	**Mail Order**
Generic	$10	$30	$10	$30	$10	$30	$10	$20	$5 Copay	$10 Copay	$5 Copay	$10 Copay
Preferred Brand Name	$20	$60	$20	$60	$20	$60	$25	$50	$10 Copay	$20 Copay	$10 Copay	$20 Copay
Non-Preferred Brand Name	$20	$60	$20	$60	$20	$60	$50	$100	$10 Copay *Member Pays the Difference	$20 Copay *Member Pays the Difference	$10 Copay *Member Pays the Difference	$20 Copay *Member Pays the Difference
Specialty Pharmacy	$10/$20	$30/$60	$10/$20	$30/$60	$10/$20	$30/$60	$10/$25/$50	$20/$50/$100	$10 Copay *Member Pays the Difference	$20 Copay *Member Pays the Difference	$10 Copay *Member Pays the Difference	$20 Copay *Member Pays the Difference
Eligibility												
Dependent Children Covered until the age of 26. Handicap dependents are covered beyond age 26, if the handicap occurred prior to the age of 26 Dependent may be extended for qualified dependents up to the age of 31												
Notes												

*Advanced/Complex Radiology requires prior authorization

This benefit summary is intended for informational purposes. Arthur J. Gallagher makes every effort to provide clear and accurate information. This highlights the major features of your health benefits program. It is not a contract and some services may require prior certification.