MoorestownTownship Board of Education
Medical, Dental and Vision Plans Effective 7/1/2026

	Aetna Medical		Aetna Medical	
Aetna Plan Name	**Garden State Plan (NJ Only Network)**		**NJ Educator's Health Plan**	
	In-Net	Out-Net	In Network	Out of Network
Drug Card	Generic/Brand/Non-Preferred		Generic/Brand/Non-Preferred	
Retail 30 Days/Mail Order 90 Days	$5/$10/$10		$5/$10/$10	
RX Maximum Out-of-Pocket	$1,6K/$3,2K		$1,6K/$3,2K	
Major Medical				
Office (PCP) Copay	$10 Copay	30% after Ded.	$10 Copay	30% after Ded.
Specialist Copay	$15 Copay	30% after Ded.	$15 Copay	30% after Ded.
Deductible (Individual/Family)	$0	$350/$700	$0	$350/$700
Co-Insurance (Carrier/Member)	90/10	70/30	90/10	70/30
Max Out-of-Pocket (Ind./Family)	$500/$1K	$2K/$5K	$500/$1K	$2K/$5K
Hospital Benefits				
Hospital In-Patient	No charge	30% after Ded.	No charge	30% after Ded.
Surgical Out-Patient	No charge	30% after Ded.	No charge	30% after Ded.
Urgent Care Center	$15 Copay	30% after Ded.	$15 Copay	30% after Ded.
Emergency Room	$125 Copay		$125 Copay	
Other				
Referral Required?	No	No	No	No
Preventative Care	No charge	30% after Ded.	No charge	30% after Ded.
Diagnostic Test	No charge	30% after Ded.	No charge	30% after Ded.
Complex Imaging	No charge	30% after Ded.	No charge	30% after Ded.
Single	$1,547.00		$1,590.00	
Employee/Child(ren)	$2,430.00		$2,499.00	
Employee/Spouse	$3,111.00		$3,200.00	
Family	$3,983.00		$4,097.00	
Please circle the tier of coverage under the plan you wish to elect.	**Single** **Employee/Child(ren)** **Employee/Spouse** **Family**		**Single** **Employee/Child(ren)** **Employee/Spouse** **Family**	

Delta Dental		
Network	**PPO + Premier**	**PPO**
	Maximum Allowable Charge	
General		
Deductible	N/A	N/A
Calendar Year Maximum	$1,350	$1,350
Carryover Max Feature		
Maximum for addt'l accumulated benefit	$675	$675
Maximum for next coverage period	$337.50	$337.50
Maximum benefit to be accumulated	$1,350	$1,350
Preventative Services		
Consultations, Exams, X-Rays	100%	100%
Cleanings (2 per year) & Fluoride	100%	100%
Space Maintainers, Sealants	100%	100%
Basic & Crown Services		
Fillings (composite & amalgam)	100%	100%
Extractions & Oral Surgery	100%	100%
Endodontics & Periodontics	100%	100%
Crowns & In-lays	100%	100%
Prosthodontics		
Bridgework, Full & Partial Dentures	80%	80%
Orthodontia Max	$1,000	$1,000
Orthodontia	80%	80%
Single	$39.00	$31.00
Employee/Child(ren)	$78.00	$63.00
Employee/Spouse	$78.00	$63.00
Family	$141.00	$112.00
Please circle the tier of coverage under the plan you wish to elect.	**Single** **EE/Child(ren)** **EE/Spouse** **Family**	**Single** **EE/Child(ren)** **EE/Spouse** **Family**

VSP Vision		
	VSP Signature Network	
	In Network	Out of Network
Exams		
Primary Eyecare	$20 Copay	Up to $50
Exams & Glasses	$25 Copay	Up to $50
Frequency	All - Every 24 Months	
Eyeglass Lens Options		
Single Lenses	Included in Exam	Up to $50
Bifocal Lenses	Included in Exam	Up to $75
Trifocal Lenses	Included in Exam	Up to $100
Progressive Lenses	$50 Copay	Up to $75
Standard Poly. for Children	Included in Exam	
Polarized	Discounted	N/A
Lenses/Frames		
Conventional Lenses	Up to $120 & 20%	Up to $105
Medically Necessary	$0 Copay	Up to $210
Frames	Up to $120 & 20%	Up to $70
Discounts		
Addt'l pair of glasses	Discounted	N/A
Retinal Screening	Up to $39	N/A
Lasik Laser correction	Discounted	N/A
Eligibility		
Single Employee/Child(ren) Employee/Spouse Family	$8.40	
Please circle the tier of coverage under the plan you wish to elect.	**Single** **Employee/Child(ren)** **Employee/Spouse** **Family**	

Employee Signature: **Date:**

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Rates benefits in this comparison are for discussion estimation purposes. Employees must compute their Chapter 44 contribution to determine payroll deduction.