Newark Board of Education
Roger León, Superintendent

2020 Aetna Medical Benefits Plan Overview - PPO Plans

	PPO 10 ** Only Available to Local 68**		PPO 15 ** Only Available to Local 68**		PPO 1525 ** Only Available to Local 68**		PPO 2020		PPO 2035		HD1500	
BENEFIT	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Deductible (Individual/Family)	None	$100 / $250	None	$100 / $250	None	$100 / $250	None	$200 / $500	$200 / $400	$800 / $2,000	$1,500 / $3,000	$1,500 / $3,000
After deductible, plan pays	100%	80%	100%	70%	100%	70%	100%	70%	80%	60%	80%	60%
Maximum Out of Pocket Payment Limit (Individual/Family)	$400 / $800	$2,000 / $5,000	$400 / $800	$2,000 / $5,000	$400 / $800	$2,000 / $5,000	$800 / $1,600	$5,000 / $12,500	$2,000 / $4,000	$5,000 / $12,500	$2,500 / $5,000	$3,500 / $7,000
Primary Care Physician Selection	Not Required		Not Required		Not Required		Not Required		Not Required		Not Required	
Preventive Care												
Routine Adult Physician Exams / Immunizations	100%	80% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	60% (no deductible)	100%	Not Covered
Routine Well Child Exams / Immunizations	100%	child immunizations only	100%	child immunizations only	100%	child immunizations only	100%	child immunizations only	100%	child immunizations only	100%	Not Covered
Routine Gynecological Care Exams	100%	80% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	60% (no deductible)	100%	Not Covered
Routine Mammograms	100%	80% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	70% (no deductible)	100%	60% (no deductible)	100%	Not Covered
Physician's Office Visits												
Primary Care Services	$10 copay	80% after deductible	$15 copay	70% after deductible	$15 copay	70% after deductible	$20 copay	70% after deductible	$20 copay	60% after deductible	80% after deductible	60% after deductible
CVS Minute Clinic	$0 copay	N/A	$0 copay	N/A	$0 copay	N/A	$0 copay	N/A	$0 copay	N/A	$0 copay after deductible	N/A
Specialist Services	$10 copay A referral is not required to visit a specialist.	80% after deductible	$15 copay A referral is not required to visit a specialist.	70% after deductible	$25 copay A referral is not required to visit a specialist.	70% after deductible	$20 copay A referral is not required to visit a specialist.	70% after deductible	$35 copay A referral is not required to visit a specialist.	60% after deductible	80% after deductible A referral is not required to visit a specialist.	60% after deductible
Maternity OB Visits	$10 copay First visit only	80% after deductible	$15 copay First visit only	70% after deductible	$25 copay First visit only	70% after deductible	$20 copay First visit only	70% after deductible	$35 copay First visit only	60% after deductible	80% after deductible Copay applies to 1st visit only	60% after deductible
Allergy Testing and Treatment	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	80%	60% after deductible	80% after deductible	60% after deductible
Diagnostics Procedures												
Laboratory*	100% in office or at Quest Diagnostics / LabCorp	80% after deductible	100% in office or at Quest Diagnostics / LabCorp	70% after deductible	100% in office or at Quest Diagnostics / LabCorp	70% after deductible	100% in office or at Quest Diagnostics / LabCorp	70% after deductible	80% after deductible Quest Diagnostics / LabCorp	60% after deductible	80% after deductible	60% after deductible
Outpatient X Ray/Radiology Services	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency Medical Care												
Emergency Room	100% after $25 facility copay (Copay waived if admitted)		100% after $50 facility copay (Copay waived if admitted)		100% after $75 facility copay (Copay waived if admitted)		100% after $100 facility copay (Copay waived if admitted)		100% after $100 facility copay (Copay waived if admitted)		80% after deductible Quest Diagnostics / LabCorp	60% after deductible
Non Emergency Care in an Emergency Room	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Ambulance	90%	80% after deductible	90%	70% after deductible	90%	70% after deductible	90%	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospital Care												
Inpatient coverage	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
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		Same as any other illness; benefit depends on place of service		Same as any other illness; benefit depends on place of service	
Other Services												
Skilled Nursing Facility	100%	80% after deductible Limited to 120 days per benefit period	100%	70% after deductible Limited to 120 days per benefit period	100%	70% after deductible Limited to 120 days per benefit period	100%	70% after deductible Limited to 120 days per benefit period	80% after deductible	60% after deductible Limited to 120 days per benefit period	80% after deductible Limited to 120 days per benefit period	60% after deductible Limited to 60 days per benefit period
Outpatient Rehabilitation Therapy (includes speech, physical, and occupational therapy)	100% after $10 copay	80% after deductible	100% after $15 copay	70% after deductible	100% after $20 copay	70% after deductible	100% after $20 copay	70% after deductible	100% after $20 copay	60% after deductible	The overall maximum per benefit period is 120 days combined In & Out-of-Network 80% after deductible	60% after deductible
Chiropractic Care	100% after $10 copay 30 visit maximum per benefit period	80% after deductible	100% after $15 copay 30 visit maximum per benefit period	70% after deductible	100% after $20 copay 30 visit maximum per benefit period	70% after deductible	100% after $20 copay 30 visit maximum per benefit period	70% after deductible	100% after $20 copay 30 visit maximum per benefit period	60% after deductible	Unlimited 80% after deductible 30 visit maximum per benefit period	60% after deductible

* Quest Diagnostics and LabCorp are the Preferred Provider for Laboratory services
** PPO 10, PPO 15 and PPO 1525 are only available to Local 68

Newark Board of Education
Roger León, Superintendent

2020 Aetna Medical Benefits Plan Overview - HMO Plans

	HMO 10		HMO 1525		HMO 2020		HMO 2035	
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Deductible (Individual/Family)	None	N/A	None	N/A	None	N/A	$200 / $400	N/A
After deductible, plan pays	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Maximum Out of Pocket Payment Limit (Individual/Family)	$5,480 / $10,960	N/A	$5,480 / $10,960	N/A	$5,480 / $10,960	N/A	$2,000 / $4,000	N/A
Primary Care Physician Selection	Required		Required		Required		Required	
Preventive Care								
Routine Adult Physician Exams / Immunizations	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Routine Well Child Exams / Immunizations	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Routine Gynecological Care Exams	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Routine Mammograms	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Physician's Office Visits								
Primary Care Services	$10 copay	Not Covered	$15 copay	Not Covered	$20 copay	Not Covered	$20 copay	Not Covered
Specialist Services	$10 copay A referral is required to visit a specialist.	Not Covered	$25 copay A referral is required to visit a specialist.	Not Covered	$20 copay A referral is required to visit a specialist.	Not Covered	$35 copay A referral is required to visit a specialist.	Not Covered
Maternity OB Visits	$10 copay First visit only	Not Covered	$25 copay First visit only	Not Covered	$20 copay First visit only	Not Covered	$35 copay First visit only	Not Covered
Allergy Testing and Treatment	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Diagnostics Procedures								
Laboratory*	100% in office or at Quest Diagnostics / LabCorp	Not Covered	100% in office or at Quest Diagnostics / LabCorp	Not Covered	100% in office or at Quest Diagnostics / LabCorp	Not Covered	80% after deductible Quest Diagnostics / LabCorp	Not Covered
Outpatient X-Ray/Radiology Services	100%	Not Covered	100%	Not Covered	100%	Not Covered	80% after deductible	Not Covered
Emergency Medical Care								
Emergency Room	100% after $35 facility copay (Copay waived if admitted)		100% after $75 facility copay (Copay waived if admitted)		100% after $100 facility copay (Copay waived if admitted)		100% after $100 facility copay (Copay waived if admitted)	
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Ambulance	100%	Not Covered	100%	Not Covered	100%	Not Covered	80% after deductible	Not Covered
Hospital Care								
Inpatient coverage	100%	Not Covered	100%	Not Covered	100%	Not Covered	80% after deductible	Not Covered
Outpatient Surgery	100%	Not Covered	100%	Not Covered	100%	Not Covered	80% after deductible	Not Covered
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								
Skilled Nursing Facility	100% Limited to 120 days per benefit period	Not Covered	100% Limited to 120 days per benefit period	Not Covered	100% Limited to 120 days per benefit period	Not Covered	80% after deductible Limited to 120 days per benefit period	Not Covered
Outpatient Rehabilitation Therapy (includes speech, physical, and occupational therapy)	100% after office copay	Not Covered	100% after $25 copay 60 visit maximum per benefit period combined in and Out-of-Network	Not Covered	100% after $20 copay 60 visit maximum per benefit period combined in and Out-of-Network	Not Covered	100% after $20 copay	Not Covered
Chiropractic Care	100% after office copay 20 visit maximum per benefit period	Not Covered	100% after $25 copay 20 visit maximum per benefit period	Not Covered	100% after $20 copay 20 visit maximum per benefit period	Not Covered	100% after $25 copay 20 visit maximum per benefit period	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

* Quest Diagnostics and LabCorp are the Preferred Provider for Laboratory services