Newark Board of Education
Roger León, Superintendent

2021 Aetna Medical Benefits Plan Overview - PPO Plans

	PPO NJEHP - eff. 01/01/2021 Only Plan available to employees hired or rehired on or after 07/01/2020		PPO 1015		PPO 2035		HD1500	
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	$350 / $700	None	$200 / $500	$200 / $400	$800 / $2,000	$1,500 / $3,000	$1,500 / $3,000
After deductible, plan pays	100%	70%	100%	70%	80%	60%	80%	60%
Maximum Out of Pocket Payment Limit (Individual/Family)	$500 / $1,000	$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**	
Preventive Care								
Routine Adult Physician Exams / Immunizations	100%	**Not covered**	100%	70% (no deductible)	100%	60% (no deductible)	100%	Not Covered
Routine Well Child Exams / Immunizations	100%	child immunizations only up to 12 months	100%	child immunizations only	100%	child immunizations only	100%	Not Covered
Routine Gynecological Care Exams	100%	**70% after deductible**	100%	70% (no deductible)	100%	60% (no deductible)	100%	Not Covered
Routine Mammograms	100%	**70% after deductible**	100%	70% (no deductible)	100%	60% (no deductible)	100%	Not Covered
Physician's Office Visits								
Primary Care Services	$10 copay	70% after deductible	$10 copay	70% after deductible	$20 copay	60% after deductible	80% after deductible	60% after deductible
Specialist Services	$15 copay A referral is **not** required to visit a specialist.	70% after deductible	$15 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	$15 copay; first visit only 100%	70% after deductible	$15 copay; first visit only 100%	70% after deductible	$35 copay; first visit only 100%	60% after deductible	100% after deductible	60% after deductible
Allergy Testing and Treatment, OV copay may apply	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	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 Quest Diagnostics / LabCorp	60% after deductible
Outpatient X-Ray/Radiology Services	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 $125 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	80% 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
Ambulance	90%	70% after deductible	90% after deductible		80% after deductible		80% after deductible	
Hospital Care								
Inpatient coverage	100%	70% after deductible	100%	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery	100%	70% after deductible	100%	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Behavioral Health Services								
Alcohol/Substance 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	
Mental Health 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	70% after deductible **Limited to 60 days per benefit period**	100% Limited to 120 days per benefit period	70% after deductible	80% after deductible Limited to 120 days per benefit period	60% after deductible	80% after deductible Limited to 120 days per benefit period The overall maximum per benefit period is 120 days combined In & Out-of-Network	60% after deductible Limited to 60 days per benefit period
Outpatient Rehabilitation Therapy (includes speech, physical, and occupational therapy)	100% after $15 copay	**70% after deductible for speech & occupational therapy and lesser of $52 or 75% of in-network cost /visit for physical therapy**	100% after $15 copay	70% after deductible	100% after $20 copay	60% after deductible	80% after deductible	60% after deductible
Chiropractic Care	100% after $15 copay 30 visit maximum per benefit period	**70% after deductible to lesser of $35/visit or 75% of in-network cost**	100% after $15 copay 30 visit maximum per benefit period	70% after deductible	100% after $20 copay 30 visit maximum per benefit period	60% after deductible	80% after deductible 30 visit maximum per benefit period	60% after deductible

Note- Quest Diagnostics and LabCorp are the Preferred Provider for Laboratory services

*** Out of Network UCR - 200% of Medicare, employee cost of coverage based % on salary.**

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2021 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	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	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	100%	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%		100%		100%		80% after deductible	
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
Behavioral Health Services								
Alcohol/Substance 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	
Mental Health 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 $10 copay	Not Covered	100% after $20 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

Note: Quest Diagnostics and LabCorp are the Preferred Provider for Laboratory services

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