2020-21 Benefit Plan Comparisons and Costs

Benefit	A1 EPO COPAYS ($$$)		A2 HIGH DEDUCTIBLE ($)		A3 EPO PRIMARY CARE 100 ($$)	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Network	I-35 Preferred Aetna Select (Open Access) and Health Network Only (HNO)	No Coverage	I-35 Preferred PPO	N/A	I-35 Preferred Aetna Select (Open Access) and Health Network Only (HNO)	No Coverage
Emergency Care Treated as In-Network	Yes	No Coverage	Yes	N/A	Yes	No Coverage
Access to Meritas Clinic (All Meritas Primary Clinics)	Yes - No Office Visit Copay	No Coverage	Yes - Deductible/ Coinsurance	N/A	Yes - No Office Visit Copay	No Coverage
Deductible (individual/family) *Calendar Year ** Aggregate	N/A	No Coverage	*/**$1,400 / $2,800	*/**$2,800 / $5,600	N/A	No Coverage
Coinsurance	N/A	No Coverage	20% After Deductible	50% After Deductible	20%	No Coverage
Out of Pocket Maximum (individual/family) *Calendar Year	*$3,500 / $7,000	No Coverage	*$3,750 / $7,500	*$25,000 / $50,000	*$1,350 / $2,700	No Coverage
PCP Office Visit / Specialist Office Visit	$40/$80 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	No Copay/20% Coinsurance	No Coverage
Urgent Care Office Visit	$80 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	20% Coinsurance	No Coverage
Basic Teledoc Visit	$40 Copay	No Coverage	$45 in 2020/ $47 in 2021	Deductible/ Coinsurance	$0 Copay	No Coverage
Dermatology/Behavioral Health Teledoc Visit	$80/$40 Copay	No Coverage	$75 Copay/$190 Inistial Visit	Deductible/ Coinsurance	20% Coinsurance	No Coverage
Mental Health Office Visit/Theraphy	$40/$40 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	20% Coinsurance	No Coverage
Other Radiology (MRI, CT, PET, MRA)	$75 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	20% Coinsurance	No Coverage
Hospital Inpatient/ Outpatient Surgery	$500 Copay per Admit	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	20% Coinsurance	No Coverage
Emergency Room	$150 Copay	$150 Copay	Deductible/ Coinsurance	Deductible/ Coinsurance	20% Coinsurance	20% Coinsurance
Chiropractic Office Visit/Skeletal Manipulation	$40/$40 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	20% Coinsurance	No Coverage
Routine Eye Exam	$10 Copay	No Coverage	Covered at 100%, Deductible Waived	30% After Deductible	Covered 100%	No Coverage
Speech, Hearing, Physical & Occupational Therapy	$40 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	20% Coinsurance	No Coverage

2020-21 Benefit Plan Comparisons and Costs

Benefit	A1 EPO COPAYS ($$$)		A2 HIGH DEDUCTIBLE ($)		A3 EPO PRIMARY CARE 100 ($$)	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Rx Generic (Up to 34 Day Supply)	$10 Copay	No Coverage	$10 Copay After Deductible	50% of Submitted Costs After Deductible and Applicable Copay	$15 Copay	No Coverage
Rx Preferred (Up to 34 Day Supply)	$50 Copay	No Coverage	$50 Copay After Deductible	50% of Submitted Costs After Deductible and Applicable Copay	$50 Copay	No Coverage
Rx Non-Preferred (Up to 34 Day Supply)	$70 Copay	No Coverage	$70 Copay After Deductible	50% of Submitted Costs After Deductible and Applicable Copay	$70 Copay	No Coverage
Rx Mail Order (35-102 Day Supply)	$30 generic / $150 preferred brand/$210 non-preferred brand	No Coverage	$30 generic/$150 preferred brand/$210 non-preferred brand	Deductible/ Coinsurance	$15 generic / $150 preferred brand /$175 non-preferred brand	No Coverage

Pharmacy Network: Advanced Control Plans-Aetna

A1 EPO Copays ($$$)	Total EE Monthly Plan Cost; *Total Monthly Retiree Cost*	Employee Monthly Contribution Paid By District	Employee Monthly Cost*	*Retiree Over Age 65 Monthly Cost*	*Cobra Monthly Cost*
Employee	$713.20	$650.00	$63.20	$784.52	$727.46
Employee + Spouse	$1,465.36	$650.00	$815.36	$1,611.90	$1,494.67
Employee + Child(ren)	$1,247.78	$650.00	$597.78	$1,372.56	$1,272.74
Family	$1,563.40	$650.00	$913.40	$1,719.74	$1,594.67
Family Split Premium**	$1,563.40	$1,300.00	$263.40		

A2 High Deductible ($)	Total EE Monthly Plan Cost; *Total Monthly Retiree Cost*	Employee Monthly Contribution Paid By District	Employee Monthly Cost*	Employee Monthly HSA Contribution Paid By District *(Retiree Not Eligible)*	*Retiree Over Age 65 Monthly Cost*	*Cobra Monthly Cost*
Employee	$603.38	$603.38	$0.00	$46.62	$663.72	$615.45
Employee + Spouse	$1,239.74	$603.38	$636.36	$46.62	$1,363.71	$1,264.53
Employee + Child(ren)	$1,055.66	$603.38	$452.28	$46.62	$1,161.23	$1,076.77
Family	$1,322.70	$603.38	$719.32	$46.62	$1,454.97	$1,349.15
Family Split Premium**	$1,322.70	$1,206.76	$115.94	$93.24		

A3 EPO Primary Care 100 ($$)	Total EE Monthly Plan Cost; *Total Monthly Retiree Cost*	Employee Monthly Contribution Paid By District	Employee Monthly Cost*	*Retiree Over Age 65 Monthly Cost*	*Cobra Monthly Cost*
Employee	$658.66	$650.00	$8.66	$724.53	$671.83
Employee + Spouse	$1,353.32	$650.00	$703.32	$1,488.65	$1,380.39
Employee + Child(ren)	$1,152.38	$650.00	$502.38	$1,267.62	$1,175.43
Family	$1,443.88	$650.00	$793.88	$1,588.27	$1,472.76
Family Split Premium**	$1,443.88	$1,300.00	$143.88		

**With Wellness Credit (Complete Biometric Screening and HRA) **Both spouse work for NKC Schools electing Family Tier*