Plainfield Board of Education Plan Comparison PASA 2020

	1	2
Medical	**Aetna OAMC $5/$5 (Administration)**	**Aetna OAMC $10/$10 (Administration)**
	CURRENT	***CURRENT***
In-Network Benefits	***In-Network Benefits***	***In-Network Benefits***
Network	*Aetna OAMC*	*Aetna OAMC*
Deductible	N/A	N/A
Coinsurance	100%	100%
Out of Pocket Max.	$1,500/$3,000	$5,000/$10,000
Lifetime Max	Unlimited	Unlimited
PCP Office Visit Copay	$5 Copay	$10 Copay
Specialist Copay	$5 Copay	$10 Copay
Hospital Inpatient	100% per admission	100% per admission
Out-Patient Surgery	100% per visit/procedure	100% per visit/procedure
Emergency Room	$25 Copay	$25 Copay
Urgent Care	$5 Copay	$10 Copay
Ambulance	100%	100%
Preventative Care	100%	100%
Diagnostic Testing/X-Rays	100%	100%
Acupuncture	$5 Copay	$10 Copay
Chiropractic	$5 Copay per visit 40 max	$10 Copay per visit 60 max
Durable Medical Equipment	100%	80%
Short Term Rehab- ST, PT, OT	$5 Copay per visit 60 max	$10 Copay per visit 60 max
Mental Health Inpatient	100%	100%
Mental Health Outpatient	$5 Copay	$10 Copay
Mental Health Office Setting	$5 Copay	$10 Copay
Out-Network Benefits	*Out-Network Benefits*	*Out-Network Benefits*
Deductible	$300/$900	$100/$200
Coinsurance	70%/30%	80%/20%
Out of Pocket Max.	$5,000/$10,000	$2,200/$4,400
Dependent Age	26	26
Single	$893.00	$1,526.12
Member Spouse	$1,620.99	$2,769.90
Parent Child	$1,609.39	$2,750.05
Family	$2,573.06	$4,396.74
Pharmacy Benefits		
Retail Generic	$5	$5
Retail Brand	$40	$40
Mail Generic	$5 up to a 90 day supply	$5 up to a 90 day supply
Mail Brand	$40 up to a 90 day supply	$40 up to a 90 day supply
Single	$178.29	$178.29
Member Spouse	$374.35	$374.35
Parent Child	$294.13	$294.13
Family	$427.83	$427.83
Combined Medical and Rx 2020 Rates		
Single	$1,071.39	$1,704.41
Member Spouse	$1,995.34	$3,144.25
Parent Child	$1,903.52	$3,044.18
Family	$3,000.89	$4,824.57

Dental	*Aetna PPO*	*Aetna DMO*
Network	Aetna PPOII Network	Aetna DMO Network
Deductible	Ind. $25/Fam. $75	$0
Preventive Services	100%	100%
Basic Services	85%	Covered according to schedule
Major Services	50%	Covered according to schedule
Annual Maximum	$1,500	N/A
Orthodontic Services	50%	Covered according to schedule
Orthodontic Lifetime Max	$1,500	N/A
Out-Network	Covered at 90th of R&C	Not Covered
Single	$37.00	$16.41
Member Spouse	$77.69	$34.47
Parent Child	$75.84	$33.66
Family	$122.14	$54.24

Vision	*NVA Vision*	
Network	In Network	Out-Network
Exam every 12 Mos.	100%	100% up to $35
Lenses every 12 Mos	Every 12 Months	
Single	100%	100% up to $25
Bifocal	100%	100% up to $40
Trifocal	100%	100% up to $55
Lenticular	100%	100% up to $60
Frame every 24 Mos.	100% up to $35	100% up to $35
Contact Lenses	Every 12 Months	
Elective	100% up to $100	100% up to $140
Medically Necessary	100%	100% up to $200
Single	$4.58	
Member Spouse	$11.46	
Parent Child	$11.46	
Family	$11.46	