2021-22 Medical 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 Primary Care Clinics/CVS Minute 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	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	$47 in 2021/ $49 in 2022	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/Therapy	$0/$0 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 Care/Spinal Manipulation	$40 Copay/Covered at 100%	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

Any discrepancy between this document and the Plan Certificate, the Plan Certificate will prevail.

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	$5 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	$55 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 /$165 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	$771.18	$705.00	$66.18	$848.30	$786.60
Employee + Spouse	$1,584.48	$705.00	$879.48	$1,742.93	$1,616.17
Employee + Child(ren)	$1,349.22	$705.00	$644.22	$1,484.14	$1,376.20
Family	$1,690.50	$705.00	$985.50	$1,859.55	$1,724.31
Family Split Premium**	$1,690.50	$1,410.00	$140.25		

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	$652.44	$652.44	$0.00	$52.56	$717.68	$665.49
Employee + Spouse	$1,340.52	$652.44	$688.08	$52.56	$1,474.57	$1,367.33
Employee + Child(ren)	$1,141.50	$652.44	$489.06	$52.56	$1,255.65	$1,164.33
Family	$1,430.22	$652.44	$777.78	$52.56	$1,573.24	$1,458.82
Family Split Premium**	$1,430.22	$1,304.88	$62.67	$105.12		

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	$712.22	$705.00	$7.22	$783.44	$726.46
Employee + Spouse	$1,463.34	$705.00	$758.34	$1,609.67	$1,492.61
Employee + Child(ren)	$1,246.06	$705.00	$541.06	$1,370.67	$1,270.98
Family	$1,561.28	$705.00	$856.28	$1,717.41	$1,592.51
Family Split Premium**	$1,561.28	$1,410.00	$75.64		

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

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