Essex County Vocational Technical Schools
Comparison of Medical Plans

	Aetna Open Access Managed Choice		*Aetna Managed Choice POS*		*Aetna HN Only*
Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In Network (No Out of Network coverage except for emergencies.)**
Benefit Period	Calendar Year		Calendar Year		Calendar Year
Deductible					
Individual	None	$100	None	$1,000	None
Family	None	$250	None	Two deductibles per family	None
	Deductible is Calendar Year		Deductible is Calendar Year		N/A
Coinsurance	100%	70%	100%	60%	100%
Maximum Out of Pocket					
Individual	$400	$2,000	$5,000		$2,500
Family	$800	$5,000	$10,000		$5,000
	Maximum Out of Pocket is Calendar Year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket. Balances from non-participating providers over our allowance are not eligible towards the Maximum Out of Pocket.		Maximum Out of Pocket is Calendar Year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket. Balances from non-participating providers over our allowance are not eligible towards the Maximum Out of Pocket.		Maximum Out of Pocket is Calendar Year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.
Benefit Period Maximum	Unlimited	$5,000,000	Unlimited	Unlimited	Unlimited
Lifetime Maximum	Unlimited	$5,000,000	Unlimited	Unlimited	Unlimited
Primary Care Physician Selection	Not Required		Required		Not Required
Doctor's Office Visits					
	100% after $10 copay	70% after deductible	100% after $10 copay	60% after deductible	100% after $20 copay
Primary Care Office Visit	A primary care physician is a general or family practitioner, internist or pediatrician		A primary care physician is a general or family practitioner, internist or pediatrician		A primary care physician is a general or family practitioner, internist or pediatrician
	100% after $10 copay	70% after deductible	100% after $10 copay	60% after deductible	100% after $40 copay
Specialist Office Visit	A referral is not required to visit a specialist.		**A referral is required to visit a specialist.**		A referral is not required to visit a specialist.
	100% after $10 copay Copay applies to first visit only	70% after deductible	100% after $10 copay Copay applies to first visit only	60% after deductible	100% after $40 copay Copay applies to first visit only
Maternity Visits	Dependent children are eligible for Maternity/Obstetrical Benefits.		Dependent children are eligible for Maternity/Obstetrical Benefits.		Dependent children are eligible for Maternity/Obstetrical Benefits.
Allergy Testing and Treatment	100%	70% after deductible	100%	60% after deductible	100% Note: A copay will apply when an office visit is billed
Preventive Care					
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%	70% no deductible	100%	60% (no deductible)	100%
Well Child Exams	100%	70% no deductible	100%	60% (no deductible)	100%
Well Child Immunizations and Lead Screening	100%	70% no deductible	100%	60% (no deductible)	100%
Diagnostic Procedures					
Laboratory	100% in office or Quest Diagnostics 100% in outpatient facility	70% after deductible	100% in office or Quest Diagnostics 100% in outpatient facility	60% after deductible	100% in office or Quest Diagnostics 100% in outpatient facility
Outpatient X-ray/Radiology Services	100% in office 100% in outpatient facility	70% after deductible	100% in office 100% in outpatient facility	60% after deductible	100% in office 100% in outpatient facility
Hospital Care					
Inpatient Admission (including maternity)	100%	70% after deductible and $200 copay	100%	60% after deductible	100% after $250 copay per day (up to 5 days)
Room and Board	100%	70% after deductible	100%	60% after deductible	100%
Pre-admission Testing	100%	70% after deductible	100%	60% after deductible	100%
Surgery in Hospital	100%	70% after deductible	100%	60% after deductible	100%
Inpatient Physician Services	100%	70% after deductible	100%	60% after deductible	100%
Outpatient Dept. Services	100%	70% after deductible	100%	60% after deductible	100%

	Aetna Open Access Managed Choice		*Aetna Managed Choice POS*		*Aetna HN Only*
Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In Network (No Out of Network coverage except for emergencies.)**
Emergency Care					
Emergency Room	100% after $25 facility copayment		100% after $50 facility copayment		100% after $100 facility copayment
	Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.		Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.		Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.
Ambulance	100%	70% after deductible	100%	60% after deductible	100%
Outpatient Surgery					
Hospital Outpatient Surgery	100%	70% after deductible	100%	60% after deductible	100% after $200 copay
Surgery in an Ambulatory SurgiCenter	100%	70% after deductible	100%	60% after deductible	100% after $100 copay
	Services performed at a non-participating ambulatory surgery center are reimbursed at the insurance company's Payment Allowance and therefore may result in significant out of pocket costs.		Services performed at a non-participating ambulatory surgery center are reimbursed at the insurance company's Payment Allowance and therefore may result in significant out of pocket costs.		
Mental Health Services					
Inpatient	100%	70% after deductible and $200 copay	100%	60% after deductible	100% after $250 copay per day (up to 5 days)
Outpatient department	100%	70% after deductible	100%	60% after deductible	100%
Office setting	100% after $10 copay	70% after deductible	100% after $10 copay	60% after deductible	100% after $40 copay
Substance Abuse Services					
Inpatient	100%	70% after deductible and $200 copay	100%	60% after deductible	100% after $250 copay per day (up to 5 days)
Outpatient department	100%	70% after deductible	100%	60% after deductible	100%
Office setting	100% after $10 copay	70% after deductible	100% after $10 copay	60% after deductible	100% after $40 copay
Alcohol Abuse Services					
Inpatient	100%	70% after deductible and $200 copay	100%	60% after deductible	100% after $250 copay per day (up to 5 days)
Outpatient department	100%	70% after deductible	100%	60% after deductible	100%
Office setting	100% after $10 copay	70% after deductible	100% after $10 copay	60% after deductible	100% after $40 copay
	Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated with the insurance company. Contact the customer service number for details.		Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated with the insurance company. Contact the customer service number for details.		Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated with the insurance company. Contact the customer service number for details.
Other Services					
Acupuncture	100%	70% after deductible	100%	60% after deductible	100%
Bariatric Surgery	100%	70% after deductible	100%	60% after deductible	100%
Diabetic Education	100% after $10 copay	70% after deductible	100% after office copayment	60% after deductible	100% after office copayment
Diabetic Supplies	100%	70% after deductible	100%	60% after deductible	100%
Durable Medical Equipment	100%	70% after deductible	100%	60% after deductible	50%
Orthotics and Prosthetics (Per NJ mandate)	100% after $10 copay	70% after deductible	100% after office copayment	60% after deductible	100% after $20 copay
Home Health Care	100%	70% after deductible	100%	60% after deductible up to 100 visits	100%
Hospice Care	100%	70% after deductible	100%	60% after deductible	100%
Infertility (including in-vitro fertilization)	100% after $10 copay	70% after deductible	100% after office copayment	60% after deductible	100% after copayment in office setting 100% in outpatient facility
	Limited to 4 egg retrievals per lifetime		Limited to 4 egg retrievals per lifetime		Limited to 4 egg retrievals per lifetime
Physical Rehabilitation Facility Inpatient Services	100%	70% after deductible	100%	60% after deductible	100%
			Limited to 60 days per benefit period		Limited to 60 days per benefit period
Private Duty Nursing	100%	70% after deductible	100%	60% after deductible	100%
	Unlimited		Limited to 30 visits per benefit period (8-hour shifts)		Limited to 30 visits per benefit period (8-hour shifts)

	Aetna Open Access Managed Choice		*Aetna Managed Choice POS*		*Aetna HN Only*
Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In Network (No Out of Network coverage except for emergencies.)**
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after $10 copay	70% after deductible	100% after office copayment	60% after deductible	100% after $20 copay
			30 visit maximum per therapy, per benefit period		30 visit maximum per therapy, per benefit period
Skilled Nursing Facility/Extended Care Center	100% up to 120 days	70% after deductible up to 60 days	100%	60% after deductible	100%
			Limited to 100 days per benefit period	Limited to 60 days per benefit period	Limited to 100 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after $10 copay	70% after deductible	100% after office copayment	60% after deductible	100% after $20 copay
	30 visit maximum per benefit period		25 visit maximum per benefit period		25 visit maximum per benefit period
Vision - Routine Eye Exam	100% after $10 copay	70% after deductible	Not covered	Not covered	100% after $40 copay
Vision Hardware	Not Covered		Not covered		$70 every two years
Prescription Drugs	Covered under freestanding Maxor program		Covered under freestanding Maxor program		Covered under Maxor program
Eligibility	Dependent children, including full-time students are covered until their 26th birthday. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31.		Dependent children, including full-time students are covered until their 26th birthday. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31.		Dependent children, including full-time students are covered until their 26th birthday. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31.
Prior Authorization	Some services/procedures require prior authorization. For a complete list, contact the insurance company's customer service number.		Some services/procedures require prior authorization. For a complete list, contact the insurance company's customer service number.		Some services/procedures require prior authorization. For a complete list, contact the insurance company's customer service number.
	You can save money when you choose to receive care from providers that participate in the insurance company's network. When you use participating hospitals or other medical facilities or doctors, you generally only pay your copayment and any applicable in-network coinsurance or deductible. Generally, if you have services performed at an out of network facility or by an out of network provider, your out of network benefits will apply. This means that you will be responsible for amounts exceeding the insurance company's allowable reimbursement for that particular service and this may result in significant out of pocket costs. You will be responsible to pay for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using the insurance company's network providers, you keep your health care costs down.		You can save money when you choose to receive care from providers that participate in the insurance company's network. When you use participating hospitals or other medical facilities or doctors, you generally only pay your copayment and any applicable in-network coinsurance or deductible. Generally, if you have services performed at an out of network facility or by an out of network provider, your out of network benefits will apply. This means that you will be responsible for amounts exceeding the insurance company's allowable reimbursement for that particular service and this may result in significant out of pocket costs. You will be responsible to pay for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using the insurance company's network providers, you keep your health care costs down.		You can save money when you choose to receive care from providers that participate in the insurance company's network. When you use participating hospitals or other medical facilities or doctors, you generally only pay your copayment and any applicable in-network coinsurance or deductible. Generally, if you have services performed at an out of network facility or by an out of network provider, your out of network benefits will apply. This means that you will be responsible for amounts exceeding the insurance company's allowable reimbursement for that particular service and this may result in significant out of pocket costs. You will be responsible to pay for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using the insurance company's network providers, you keep your health care costs down.
	Please note that the benefit highlights are provided for informational purposes. We have made every effort to provide clear and accurate information pertaining to these benefit highlights. However, because we expect continued guidance from regulators on issues pertaining to Federal health care reform, the information that has been provided is subject to change. The insurance company will provide notice of such changes to members pursuant to State and Federal requirements.		Please note that the benefit highlights are provided for informational purposes. We have made every effort to provide clear and accurate information pertaining to these benefit highlights. However, because we expect continued guidance from regulators on issues pertaining to Federal health care reform, the information that has been provided is subject to change. The insurance company will provide notice of such changes to members pursuant to State and Federal requirements.		Please note that the benefit highlights are provided for informational purposes. We have made every effort to provide clear and accurate information pertaining to these benefit highlights. However, because we expect continued guidance from regulators on issues pertaining to Federal health care reform, the information that has been provided is subject to change. The insurance company will provide notice of such changes to members pursuant to State and Federal requirements.
	This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.		This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.		This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.