Pace University
January 1, 2023 - December 31, 2023
Medical Detailed Benefit Summary

	Aetna		
Plan Name	**Network Core Plan**	**Choice Plan**	
Network	**Open Access Elect Choice**	**Open Access Managed Choice**	
	In Network	**In Network**	**Out of Network**
Deductible	N/A	$750/$1,500	$2,000/$4,000
Coinsurance	Covered 100%	85%	65%
Out of Pocket Maximum	$2,000/$4,000	$2,000/$4,000	$5,000/$10,000
Annual Maximum , Unless noted otherwise	Unlimited	Unlimited	Unlimited
Lifetime Maximum, Unless noted otherwise	Unlimited	Unlimited	Unlimited
Presciption Drug Deductible	$125/$375 waived for generic	$125/$375 waived for generic	$125/$375 waived for generic
Pharmacy Maximum Out of Pocket	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000
Prescription Drugs	$20/$45/$70 (Generic Preventive Medication - $0 copay & not subject to deductible)	$20/$45/$70 (Generic Preventive Medication - $0 copay & not subject to deductible)	30% of submitted cost after applicable copay
Mail Order Prescription Drugs (Three (3) month Supply)	$20/$45/$70 (Generic Preventive Medication - $0 copay & not subject to deductible)	$20/$45/$70 (Generic Preventive Medication - $0 copay & not subject to deductible)	In-Network Benefit Only
Oral Contraceptive Coverage	Included	Included	Included
PCP Office Visits	$30	$30	Deductible & 70% Coinsurance
Specialist Visits	$50	$50	Deductible & 70% Coinsurance
Telehealth Connection Services	$30	$30	Not covered
OB/GYN Visits	Office Visit - $30/$50 copay Prenatal & Preventive care - Covered 100%	Office Visit - $30/$50 copay Prenatal & Preventive care - Covered 100%	Deductible and 70% Coinsurance
Routine Preventive Care (adult)	100%	100%	Deductible & 70% Coinsurance

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Well Child Exams (through age 18)	100%	100%	100%
Vision Coverage	1 routine exam covered every 24 months	1 routine exam covered every 24 months	Deductible & 70% Coinsurance; 1 routine exam covered every 24 months
Gym Reimbursement	Reimbursement program up to $200/ee and $100/sp/dp every 6 months for 50 visits.	Reimbursement program up to $200/ee and $100/sp/dp every 6 months for 50 visits.	
Lab and X-ray	Participating lab - 100% Office Visit - $30/$50 copay (If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing) Outpatient - 100%, deductible waived	Participating lab - 100% Office Visit - $30/$50 copay (If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing) Outpatient - 100%, deductible waived	Deductible & 70% Coinsurance
Advanced Radiology	Office Visit - $30/$50 copay (If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing) Outpatient - 100%	100% (If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing)	Deductible & 70% Coinsurance
Chiropractic	$50 Unlimited visits per calendar yr	$50 Unlimited visits per calendar yr	Deductible & 70% Coinsurance Unlimited visits per calendar yr
Ambulance Service	100% (Emergency Use only)	Deductible & 85% Coinsurance (Emergency Use only)	Deductible & 85% Coinsurance (Emergency Use only)
Emergency Room	$85 per visit; Waived if admitted	$85 per visit; Waived if admitted	$85 per visit; Waived if admitted
Urgent Care	$30 per visit	$30 per visit	$30 per visit
Hospitalization	100%	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	100%	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Mental Health	100%	Deductible & Coinsurance	Deductible & Coinsurance

Retirees

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Outpatient Mental Health	Office Visit - $30 copay Outpatient Facility - 100%	Office Visit - $30 copay Outpatient Facility - 100%	Deductible & 70% Coinsurance
Substance Abuse	Inpatient - 100%; Office Visit - $30 Copay Outpatient Services - 100%	Inpatient - Deductible & Coinsurance Office Visits - $30 Copay Outpatient Services - 100%	Inpatient - Deductible & Coinsurance Office Visits - Deductible & 70% Coinsurance Outpatient Services - Deductible & 70% Coinsurance
Inpatient Physical Therapy	100%; 60 days maximum per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities	Deductible & Coinsurance; 60 days maximum per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities	Deductible & Coinsurance; 60 days maximum per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities
Outpatient Physical Therapy	$50 Copay Limited to 90 visits per year. Unlimited for early intervention services from birth to age 3. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy	$50 Copay Limited to 90 visits per year. Unlimited for Early Intervention Services from birth to age 3. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy	Deductible & 70% Coinsurance Limited to 90 visits per year. Unlimited for Early Intervention Services from birth to age 3. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy
Hospice Care	100%	Deductible & Coinsurance	Deductible & Coinsurance
Home Health Care (includes Outpatient Private Duty Nursing)	100% Home health care services include private duty nursing Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less	Deductible & 75% Coinsurance Home health care services include private duty nursing; Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less	Deductible & 75% Coinsurance Home health care services include private duty nursing; Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less
Skilled Nursing Facility	100% Limited to 60 days per year Includes Rehabilitation Hospital and Sub-Acute Facilities	Deductible & Coinsurance Limited to 60 days per year Includes Rehabilitation Hospital and Sub-Acute Facilities	Deductible & Coinsurance Limited to 60 days per year Includes Rehabilitation Hospital and Sub-Acute Facilities

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TMJ- Surgical and Non Surgical - Always excludes appliances & orthodontic treatment. Subject to medical necessity.	Office Visit - $30/$50 copay Inpatient and Outpatient facility - 100%.	Office Visit - $30/$50 copay Inpatient and Outpatient facility - Deductible & Coinsurance	Office Visit - Deductible & 70% Coinsurance Inpatient and Outpatient facility - Deductible & Coinsurance
Infertility	Office Visit - $30/$50 copay Inpatient & Outpatient Facility - 100%; Comprehensive (includes artificial insemination) - Unlimited maximum Advanced Infertility (IV, ZIFT, GIFT) - Unlimited maximum	Office Visit - $30/$50; Inpatient & Outpatient Facility - Deductible & Coinsurance Comprehensive (includes artificial insemination) - Unlimited maximum Advanced Infertility (IV, ZIFT, GIFT) - Unlimited maximum	Deductible & Coinsurance; Comprehensive (includes artificial insemination) - Unlimited maximum Advanced Infertility (IV, ZIFT, GIFT) - Unlimited maximum
Abortion	Office Visit - $30/$50 copay Inpatient & Outpatient Facility - 100%	Office Visit - $30/$50 copay Inpatient & Outpatient Facility - Deductible & Coinsurance	Office Visit - Deductible & 70% Coinsurance Inpatient & Outpatient Facility - Deductible & Coinsurance
Dependent Age	26, End of calendar yr	26, End of calendar yr	26, End of calendar yr
Durable Medical Equip.	100%; Unlimited maximum	Deductible & Coinsurance; Unlimited maximum	Deductible & Coinsurance; Unlimited maximum
Out of Network Reasonable & Customary	N/A	N/A	300% of Medicare
Pre-certification required	Yes, coordinated by provider/ PCP	Yes, coordinated by provider/ PCP	Yes, EE responsible
Penalty for Failure to Pre-certify	N/A	N/A	Lesser of 50% or $500
Acupuncture	$30 copay	$30 copay; deductible waived	30%; after deductible
Hearing Aids	100% Covered	15%; after deductible Limited to 1 hearing aid per ear every 3 years	35%; after deductible Limited to 1 hearing aid per ear every 3 years