Pace University
2027 Medical Plan Comparison Chart

	Aetna 2025 Plans			
Plan Name	**Consumer Core HDHP**	**Network Core Plan**	**Choice PPO**	
Network	**Open Access Aetna Select Network**	**Open Access Aetna Select Network**	**Open Access Choice POS II Network**	
	In Network	**In Network**	**In Network**	**Out of Network**
Deductible	$1,750/$3,500 (Cumulative)	$250 / $500	$850/$1,700	$2,500/$5,000
Coinsurance	90%	Covered 100%	85%	50%
Out of Pocket Maximum (Medical and Rx)	$2,500/$5,000	**$5,000/$10,000**	**$5,000/$10,000**	**$10,000/$20,000**
Presciption Drug Deductible	Combined with medical	$125/$375 waived for generic	$125/$375 waived for generic	$125/$375 waived for generic
Prescription Drugs	Deductible and then 20%/30%/50% Coinsurance up to the Out of Pocket Maximum (Generic Preventive Medication - $0 copay & not subject to deductible)	$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)	Deductible and then 20%/30%/50% Coinsurance (Generic Preventive Medication - $0 copay & not subject to deductible)	$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	Included
PCP Office Visits	Deductible and Coinsurance	$30	$30	Deductible & Coinsurance
Specialist Visits	Deductible and Coinsurance	$50	$50	Deductible & Coinsurance
Telehealth Connection	Deductible and Coinsurance	$30 / $50	$30 / $50	Not covered
OB/GYN Visits	Deductible and Coinsurance; Preventive care - Covered 100%	Office Visit - $50 copay Preventive care - Covered 100%	Office Visit - $30/$50 copay Preventive care - Covered 100%	Deductible and Coinsurance
Routine Preventive Care (adult)	100%	100%	100%	Deductible & Coinsurance
Well Child Exams (through age 18)	100%	100%	100%	100%
Vision Coverage	1 routine exam covered every 24 months; Separate vision plan through Aetna Vision	1 routine exam covered every 24 months; Separate vision plan through Aetna Vision	1 routine exam covered every 24 months; Separate vision plan through Aetna Vision	Deductible & Coinsurance; 1 routine exam covered every 24 months; Separate vision plan through Aetna Vision
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.	Reimbursement program up to $200/ee and $100/sp/dp every 6 months for 50 visits.	
Lab and X-ray	Deductible & Coinsurance	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%	Participating lab - 100%, no deductible 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 & Coinsurance
Advanced Radiology	Deductible & Coinsurance	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 & Coinsurance
Chiropractic	Deductible & Coinsurance Unlimited visits per calendar yr	$50 Unlimited visits per calendar yr	$50 Unlimited visits per calendar yr	Deductible & Coinsurance Unlimited visits per calendar yr
Ambulance Service	Deductible & Coinsurance (Emergency Use only)	100% (Emergency Use only)	Covered 100% (Emergency Use only)	Covered 100% (Emergency Use only)
Emergency Room	Deductible & Coinsurance	$200 per visit; Waived if admitted	$200 per visit; Waived if admitted	$200 per visit; Waived if admitted
Urgent Care	Deductible & Coinsurance	$50 per visit	$50 per visit	$50 per visit
Hospitalization	Deductible & Coinsurance	100% after deductible	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	100% after deductible	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Mental Health	Deductible & Coinsurance	100% after deductible	Deductible & Coinsurance	Deductible & Coinsurance

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Outpatient Mental Health	Deductible & Coinsurance	Office Visit - $30 copay Outpatient Facility - 100%	Office Visit - $30 copay Outpatient Facility - 100%	Deductible & Coinsurance
Substance Abuse	Deductible & Coinsurance	Inpatient - 100%; after deductible 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
Outpatient Physical Therapy	Deductible & 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	$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	Deductible & Coinsurance	100% after deductible	Deductible & Coinsurance	Deductible & Coinsurance
Home Health Care (includes Outpatient Private Duty Nursing)	Deductible & Coinsurance Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less	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 & 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 & 25% 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	Deductible & Coinsurance Limited to 60 days per year Includes Rehabilitation Hospital and Sub-Acute Facilities	100% after deductible 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
Infertility	Deductible & Coinsurance; Comprehensive (includes artificial insemination) - Unlimited maximum Advanced Infertility (IV, ZIFT, GIFT) - Unlimited maximum	Office Visit - $30/$50 copay Inpatient & Outpatient Facility - 100% after deductible; 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	Deductible & Coinsurance	Office Visit - $30/$50 copay Inpatient & Outpatient Facility - 100% after deductible	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	26, End of calendar yr
Durable Medical Equip.	Deductible & Coinsurance; Unlimited maximum	100%; after deductible	Deductible & Coinsurance; Unlimited maximum	Deductible & Coinsurance; Unlimited maximum
Out of Network Reasonable & Customary	N/A	N/A	N/A	300% of Medicare
Pre-certification required	Yes, coordinated by provider/PCP	Yes, coordinated by provider/ PCP	Yes, coordinated by provider/ PCP	Yes, EE responsible
Penalty for Failure to Pre-certify	N/A	N/A	N/A	Lesser of 50% or $500

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