

## **Schedule of benefits**

**Prepared for:**

Employer: State Teachers Retirement System of Ohio (STRS Ohio)

Contract number: ASA-0351630-A

Control number: 232351

Plan name: Aetna Basic Health Care Assistance Plan  
Retirees Indemnity (Traditional Choice) Medical Plan  
Not eligible for Medicare or enrolled in Medicare  
living outside the network area

Schedule of benefits: 3E

Plan effective date: January 1, 2024

Plan issue date: August 20, 2023

**Third Party Administrative Services provided by Aetna Life Insurance Company**

## Schedule of benefits

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This schedule of benefits (schedule) lists the **copayments, deductibles, or payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

The schedule of benefits provides a summary of cost sharing and goes with the Medical Plan Description (MPD). Detailed descriptions of **covered services** are found in the MPD.

Words that are in bold are defined in the *Glossary* section of the Medical Plan Description (MPD).

### How your cost share works

- The **copayments and deductibles**, if any, listed in the schedule below are the amounts that you pay for **covered services**, up to the **maximum out-of-pocket** amount.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **copayments, deductibles**, and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this planSee the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at <https://www.aetna.com/>. Simply click on the "Log in" button and follow the prompts.

#### Important note:

**Covered services** are subject to the **copayment, deductible, maximum out-of-pocket**, limits, or **payment percentage** unless otherwise stated in this schedule.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

**Important note:**

If you are eligible for Medicare, benefit payments will be calculated as if Medicare is the primary payer, even if you have not actually enrolled for Medicare. Please see page 39 of your Medical Plan Description for more details. If you have any questions, please contact Member Services by logging onto your Aetna secure member website at [www.aetna.com](http://www.aetna.com) or at the toll-free number on your ID card.

**How your deductible works**

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from a **provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentages**, if any, for **covered services** after you meet your **deductible**, up until you reach the **maximum out-of-pocket**.

**How your PCP or physician office visit cost share works**

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

**How your maximum out-of-pocket works**

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

**Contact us**

We are here to answer questions. See the *Contact us* section in your Medical Plan Description.

This schedule replaces any schedule of benefits previously in use.

**Plan features and general coverage provisions**

This section explains the **deductible**, **maximum out-of-pocket limit** and limitations listed in this schedule.

**Precertification covered services reduction****(Does not apply if you are enrolled in Medicare)**

Your Medical Plan Description contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A \$200 benefit reduction applied separately to each type of **covered service**

The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty because you didn't get **precertification** is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**.

**Copayment**

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit.

## Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	Amount
Individual	\$300 per year

## Deductible provisions

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

## Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

## Deductible waiver

There is no **deductible** for the following **covered services**:

- **PCP**
- Preventive care
- Family planning services – female contraceptives

## Payment Percentage

This is the percentage of the bill you pay after you meet your **deductible**.

## Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	Amount
Individual	\$1,100 per year

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **deductible**, **payment percentage**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

## Individual maximum out-of-pocket limit

After the amount of the cost share and **deductible** paid during the year for **covered services** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** for the remainder of the year.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-**covered services** which are identified in the MPD and the schedule
- Charges, expenses or costs in excess of the **recognized charge**

## Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the Medical Plan Description.

## Covered services

### Abortion

Description	Cost share
Abortion	Covered based on type of service and where it is received

### Acupuncture

Description	Cost share
Acupuncture	80% per visit after <b>deductible</b>

### Ambulance services

Description	Cost share
Emergency services	80% per trip after <b>deductible</b>
Non-emergency services	80% per trip after <b>deductible</b>

### Applied behavior analysis

Description	Cost share
Applied behavior analysis	Covered based on type of service and where it is received

### Autism spectrum disorder

Description	Cost share
Diagnosis and testing	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received

## Behavioral health

### Mental health treatment

Coverage provided is the same as for any other illness

Description	Cost share
Inpatient services- <b>room and board</b> including <b>residential treatment facility</b>	80% per admission after <b>deductible</b>
Other inpatient services and supplies Other <b>residential treatment facility</b> services and supplies	80% per admission after <b>deductible</b>

Description	Cost share
Outpatient office visit to a <b>physician</b> or <b>behavioral health provider</b>	80% per visit after <b>deductible</b>
<b>Physician</b> or <b>behavioral health provider telemedicine</b> consultation	80% per visit after <b>deductible</b>
Outpatient <b>mental health disorders telemedicine</b> cognitive therapy consultations by a <b>physician</b> or <b>behavioral health provider</b>	80% per visit after <b>deductible</b>
* <b>Telemedicine</b> consultations are available from a number of different kinds of <b>providers</b> under your plan. Contact Member Services to get more information about your options, including specific cost sharing amounts.	

Description	Cost share
Other outpatient services including: <ul style="list-style-type: none"> <li>Behavioral health services in the home</li> <li>Partial hospitalization treatment</li> <li>Intensive outpatient program</li> </ul>	80% per visit after <b>deductible</b>

### Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	Cost share
Inpatient services-room and board during a hospital stay	80% per admission after <b>deductible</b>
Other inpatient services and supplies during a hospital stay	80% per admission after <b>deductible</b>

Description	Cost share
Outpatient office visit to a <b>physician</b> or <b>behavioral health provider</b>	80% per visit after <b>deductible</b>
<b>Physician</b> or <b>behavioral health provider telemedicine</b> consultation	80% per visit after <b>deductible</b>
Outpatient <b>telemedicine</b> cognitive therapy consultations by a <b>physician</b> or <b>behavioral health provider</b>	80% per visit after <b>deductible</b>

\* **Telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Contact Member Services to get more information about your options, including specific cost sharing amounts.

Description	Cost share
Other outpatient services including: <ul style="list-style-type: none"> <li>• Behavioral health services in the home</li> <li>• Partial hospitalization treatment</li> <li>• Intensive outpatient program</li> </ul>	80% per visit after <b>deductible</b>

### Clinical trials

Description	Cost share
Experimental or investigational therapies	Covered based on type of service and where it is received
Experimental or investigational therapies lifetime maximum	\$10,000
Routine patient costs	Covered based on type of service and where it is received

### Diabetic services, equipment, and self-care programs

Description	Cost share
Diabetic services	Covered based on type of service and where it is received
Diabetic insulin pump equipment	80% per item after <b>deductible</b>
Diabetic self-care programs	Covered based on type of service and where it is received
For diabetic testing supplies, insulin, and syringes, see separate <b>prescription</b> drug plan.	

### Durable medical equipment (DME)

Description	Cost share
DME	80% per item after <b>deductible</b>

### Emergency services

Description	Cost share
Emergency room	\$150 then the plan pays 80% per visit, no <b>deductible</b> applies

**Emergency services important note:** You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

### Family planning services

#### Female voluntary sterilization

Description	Cost share
Inpatient	100% per admission, no <b>deductible</b> applies
Outpatient	100% per visit, no <b>deductible</b> applies

#### Voluntary sterilization for males

Description	Cost share
Outpatient	100% per visit, no <b>deductible</b> applies



## Habilitation therapy services

### Physical (PT), occupational (OT) therapies

Description	Cost share
PT, OT therapies	80% per visit after <b>deductible</b>

### Speech therapy (ST)

Description	Cost share
ST therapy	80% per visit after <b>deductible</b>

## Home health care

A visit is a period of 4 hours or less

Description	Cost share
Home health care	80% per visit after <b>deductible</b>

### Home health care important note:

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

## Hospice care

Description	Cost share
Inpatient services - <b>room and board</b>	80% per admission after <b>deductible</b>

Description	Cost share
Other inpatient services and supplies	80% per admission after <b>deductible</b>

Description	Cost share
Outpatient services	80% per visit after <b>deductible</b>

Limit per lifetime	unlimited
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### Hospice important note:

This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

## Hospital care

Description	Cost share
Inpatient services – <b>room and board</b>	80% per admission after <b>deductible</b>

Description	Cost share
Other inpatient services and supplies	80% per admission after <b>deductible</b>

## Infertility services

### Basic infertility

Description	Cost share
Treatment of basic infertility	Covered based on type of service and where it is received

## Jaw joint disorder

Includes TMJ

Description	Cost share
Jaw joint disorder treatment	Covered based on type of service and where it is received

## Maternity and related newborn care

Includes complications

Description	Cost share
Inpatient services – room and board	80% per admission after deductible
Other inpatient services and supplies	80% per admission after deductible
Services performed in physician or specialist office or a facility	80% per visit after deductible
Other services and supplies	80% after deductible

### Maternity and related newborn care important note:

Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the booklet. It will give you more information about coverage for maternity care under this plan.

## Obesity surgery

Description	Cost share
Inpatient services – room and board	80% per admission after deductible
Other inpatient services and supplies	80% per admission after deductible

Description	Cost share
Outpatient services	80% per visit after deductible

## Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Cost share
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received

## Outpatient surgery

Description	Cost share
At <b>hospital</b> outpatient department	80% after <b>deductible</b>
At facility that is not a <b>hospital</b>	80% after <b>deductible</b>
At the <b>physician</b> office	80% after <b>deductible</b>

## Physician and specialist services

### Physician - general or family practitioner

Description	Cost share
<b>Physician</b> office hours (not surgical, not preventive)	\$20 then the plan pays 100% per visit, no <b>deductible</b> applies
<b>Physician</b> surgical services	80% per visit after <b>deductible</b>
Allergy injections, testing, and treatment	80% per visit after <b>deductible</b>

Description	Cost share
<b>Physician</b> visit during inpatient <b>stay</b>	80% per visit after <b>deductible</b>

Description	Cost share
<b>Physician</b> telemedicine consultation	\$20 then the plan pays 100% per visit, no <b>deductible</b> applies

### Specialist

Description	Cost share
<b>Specialist</b> office hours (not surgical, not preventive)	80% per visit after <b>deductible</b>
<b>Specialist</b> surgical services	80% per visit after <b>deductible</b>
Allergy injections, testing, and treatment	80% per visit after <b>deductible</b>

Description	Cost share
<b>Specialist</b> telemedicine consultation	80% per visit after <b>deductible</b>

### All other services not shown above

Description	Cost share
All other services	80% per visit after <b>deductible</b>

## Preventive care

Description	Cost share
Preventive care services	100% per visit, no <b>deductible</b> applies
Breast feeding counseling and support	100% per visit, no <b>deductible</b> applies
Breast feeding counseling and support limit	6 visits/12 months in a group or individual setting Visits that exceed the limit are covered under the <b>physician</b> services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months  Manual pump: 1 per pregnancy  Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no <b>deductible</b> applies
Counseling for alcohol or drug misuse visit limit	5 visits/calendar year
Counseling for genetic risk for breast and ovarian cancer	100% per visit, no <b>deductible</b> applies
Counseling for obesity, healthy diet	100% per visit, no <b>deductible</b> applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per calendar year, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no <b>deductible</b> applies
Counseling for sexually transmitted infection visit limit	2 visits/calendar year
Counseling for tobacco cessation	100% per visit, no <b>deductible</b> applies
Counseling for tobacco cessation visit limit	8 visits/calendar year
Family planning services (female contraception counseling)	100% per visit, no <b>deductible</b> applies
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Female contraceptive device provided, administered, or removed, by a <b>physician</b> during an office visit	100%, no <b>deductible</b> applies

<b>Description</b>	<b>Cost share</b>
Immunizations	100%, no <b>deductible</b> applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>
Routine cancer screenings	100% per visit, no <b>deductible</b> applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF  The comprehensive guidelines supported by the Health Resources and Services Administration  For more information contact your <b>physician</b> or see the <i>Contact us</i> section
Routine lung cancer screening	100% per visit, no <b>deductible</b> applies
Routine lung cancer screening limit	1 screening every calendar year  Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no <b>deductible</b> applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents  Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 18; 1 exam every calendar year after age 18  High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Routine skin cancer screening	100% per visit, no <b>deductible</b> applies
Routine skin cancer screening limit	1 screening every calendar year
Well woman GYN exam	100% per visit, no <b>deductible</b> applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

### **Private duty nursing**

Up to 8 hours equals one shift

<b>Description</b>	<b>Cost share</b>
Outpatient services	80% per visit after <b>deductible</b>

### Prosthetic devices

Description	Cost share
Prosthetic devices	80% per item after <b>deductible</b>
Maximum benefit for wigs	1 every 3 years

### Reconstructive surgery and supplies

Including breast **surgery**

Description	Cost share
<b>Surgery</b> and supplies	Covered based on type of service and where it is received

### Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

#### Cardiac rehabilitation

Description	Cost Share
Cardiac rehabilitation	Covered based on type of service and where it is received

#### Pulmonary rehabilitation

Description	Cost Share
Pulmonary rehabilitation	Covered based on type of service and where it is received

#### Cognitive rehabilitation

Description	Cost Share
Cognitive rehabilitation	Covered based on type of service and where it is received

### Physical and occupational therapies

Description	Cost Share
	80% per visit after <b>deductible</b>

### Speech therapy (ST)

Description	Cost Share
	80% per visit after <b>deductible</b>

### Spinal Manipulation

Description	Cost Share
	80% per visit after <b>deductible</b>

### Skilled nursing facility

Description	Cost Share
Inpatient services - <b>room and board</b>	80% per admission after <b>deductible</b>
Other inpatient services and supplies	80% per admission after <b>deductible</b>

Day limit per confinement	90
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## Tests, images and labs – outpatient

### Diagnostic complex imaging services

Description	Cost Share
	80% per visit after <b>deductible</b>

### Diagnostic lab work

Description	Cost Share
	80% per visit after <b>deductible</b>

### Diagnostic x-ray and other radiological services

Description	Cost Share
	80% per visit after <b>deductible</b>

## Therapies

### Chemotherapy

Description	Cost Share
Chemotherapy services	80% per visit after <b>deductible</b>

### Gene-based, cellular and other innovative therapies (GCIT)

Description	Cost share
Services and supplies	Covered based on type of service and where it is received

### Infusion

Outpatient services

Description	Cost share
	80% per visit after <b>deductible</b>

### Radiation therapy

Description	Cost share
Radiation therapy	80% per visit after <b>deductible</b>

### Respiratory therapy

Description	Cost share
Respiratory therapy	80% per visit after <b>deductible</b>

### Transplant services

Description	Cost share
Inpatient services and supplies	80% per transplant after <b>deductible</b>
Physician services	Covered based on type of service and where it is received

### Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	Cost share
Urgent care facility	\$40 then the plan pays 80% per visit after <b>deductible</b>

### Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**.

<b>Description</b>	<b>Cost share</b>
Non- <b>emergency services</b>	\$20 then the plan pays 100% per visit, no <b>deductible</b> applies
Preventive care immunizations	100% per visit, no <b>deductible</b> applies
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your <b>physician</b>
Preventive screening and counseling services	100% per visit, no <b>deductible</b> applies
Preventive screening and counseling limits	See the Preventive care services section of the SOB