Retirees Indemnity (Traditional Choice) Medical Plan

Not eligible for Medicare living outside the network area or Enrolled in Medicare Parts A & B or Enrolled in Medicare Part A

Schedule of Benefits

Prepared exclusively for:

Employer	State Teachers Retirement System of Ohio (STRS Ohio)
Contract number:	ASA-351630-A
	Schedule of Benefits 3B
Plan effective date:	January 1, 2019
Plan issue date:	November 9, 2018

These benefits are not insured with Aetna but will be paid from STRS Ohio's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **payment percentage** and any limits that apply to the services.

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 55 of your Booklet for more details. If you have any questions, please contact Member Services by logging onto your Aetna secure member website at www.aetna.com or at the toll-free number on your ID card.

How to read your schedule of benefits

- The **deductibles** and **payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles** and any remaining **payment percentage**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**

Important note:
All **covered benefits** are subject to the Calendar Year **deductible** and **payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at www.aetna.com or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

Plan features	Deductible/Maximums
Deductible	
You have to meet your Calendar Year **deductible** before this plan pays for benefits.	
Individual	$2,500 per Calendar Year
Deductible waiver	
The Calendar Year **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives	
Maximum out-of-pocket limit	
Maximum out-of-pocket limit per Calendar Year.	
Individual	$6,500 per Calendar Year
Precertification covered benefit reduction **(Does not apply if you are enrolled in Medicare Part A)**	
The booklet contains a complete description of the **precertification** program. You will find details on **precertification** requirements in the *Medical necessity and precertification requirements* section. Failure to **precertify** your **eligible health services** when required will result in the following benefits reduction: • A $200 benefit reduction will be applied separately to each type of **eligible health services** or • The **eligible health services** will not be covered. The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered benefit**, and will not be applied to the **deductible** amount or the **maximum out-of-pocket limit**, if any.	

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Preventive care and wellness	
Routine physical exams	
Performed at a **physician's** office	100% (of the **recognized charge**) per visit No **deductible** applies.
Covered persons through age 21:	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 guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit
Preventive care immunizations	
Performed in a facility or at a **physician's** office	100% (of the **recognized charge**) per visit No **deductible** applies
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Well woman preventive visits routine gynecological exams (including pap smears)	
Performed at a **physician's**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the **recognized charge**) per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Preventive screening and counseling services	
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% (of the **recognized charge**) per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:	
Maximum visits per Calendar Year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)
Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Misuse of alcohol and/or drugs maximums:	
Maximum visits per Calendar Year	5 visits
Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Use of tobacco products maximums:	
Maximum visits per Calendar Year	8 visits
Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Sexually transmitted infection counseling maximums:	
Maximum visits per Calendar Year	2 visits
Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.	
Genetic risk counseling for breast and ovarian cancer maximums:	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)	
Routine cancer screenings	100% (of the **recognized charge**) per visit No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening per Calendar Year
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.	
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**	
Preventive care services only	100% (of the **recognized charge**) per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.	
Comprehensive lactation support and counseling services	
Lactation counseling services – facility or office visits	100% (of the **recognized charge**) per visit No **deductible** applies
Lactation counseling services maximum per 12 months either in a group or individual setting	6 visits
Important note: Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.	

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Breast feeding durable medical equipment	
Breast pump supplies and accessories	100% (of the **recognized charge**) per item No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the booklet for limitations on breast pump and supplies.	
Family planning services – female contraceptives	
Counseling services	
Female contraceptive counseling services office visit	100% (of the **recognized charge**) per visit No **deductible** applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits
Important note: Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.	
Devices	
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% (of the **recognized charge**) per item No **deductible** applies
Female voluntary sterilization	
Inpatient	100% (of the **recognized charge**) per admission No **deductible** applies
Outpatient	100% (of the **recognized charge**) per visit No **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Physicians and other health professionals	
Physicians and **specialists** office visits (non-surgical)	
Physician services	
Office hours visits (non-surgical) non preventive care	
First 2 visits per Calendar Year	$20 then the plan pays 100% (of the balance of the **recognized charge**) per visit thereafter No **deductible** applies
Visits thereafter in the same Calendar Year	100% (of the **recognized charge**) per visit
Allergy injections	
Performed at a **physician's** or **specialist** office when you do not see the **physician**	80% (of the **recognized charge**) per visit
Allergy testing, treatment and injections	
Performed at a **physician's** or **specialist** office	80% (of the **recognized charge**) per visit
Immunizations that are not considered preventive care	
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.
Specialist	
Specialist office visits	
Office hours visits (non-surgical)	80% (of the **recognized charge**) per visit
Physician surgical services	
Physicians and **specialists** office visits	
Performed at a **physician's** office	80% (of the **recognized charge**) per visit
Performed at a **specialist's** office	80% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Alternatives to physician office visits	
Walk-in clinic visits	
Preventive Care Services	
Immunizations	100% per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
All other non preventive care services for which cost sharing is not shown above	
All other services First 2 visits per Calendar Year	$20 then the plan pays 100% (of the balance of the **recognized charge**) per visit thereafter No **deductible** applies
Visits thereafter in the same Calendar Year	80% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Hospital and other facility care	
Hospital care	
Inpatient **hospital**	80% (of the **recognized charge**) per admission
Alternatives to hospital stays	
Outpatient surgery and physician surgical services	
	80% (of the **recognized charge**) per visit
Home health care	
Outpatient	80% (of the **recognized charge**) per visit
Hospice care	
Inpatient facility	80% (of the **recognized charge**) per admission
Maximum days per lifetime	Unlimited
Hospice care	
Outpatient	80% (of the **recognized charge**) per visit
Outpatient private duty nursing	
Outpatient private duty nursing	80% (of the **recognized charge**) per visit
Skilled nursing facility	
Inpatient facility	80% (of the **recognized charge**) per admission
Maximum days per confinement	90

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Eligible health services*	
Emergency services and urgent care	
Emergency services	
Hospital emergency room	$150 then the plan pays 80% (of the balance of the **recognized charge**) per visit
Important Note: A separate hospital emergency room **copayment/payment percentage** will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room **copayment/payment percentage** will be waived and your inpatient **copayment/payment percentage** will apply.	
Urgent Care	
Urgent medical care (at a non-**hospital** free standing facility)	$40 then the plan pays 80% (of the balance of the **recognized charge**) per visit thereafter
A separate urgent care **deductible** will apply for each visit to an **urgent care provider**.	

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Eligible health services*	
Specific conditions	
Autism spectrum disorder	
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other **illness** under this plan	
Birthing Center	
Inpatient	80% (of the **recognized charge**) per admission
Diabetic equipment, supplies and education	
Diabetic insulin pump equipment, pump supplies and education **For diabetic testing supplies, insulin, and syringes, see separate prescription drug plan.**	80% (of the **recognized charge**) per item/visit
Family planning services - other	
Voluntary sterilization for males	
Outpatient	80% **(**of the **recognized charge**) per visit
Abortion	
Outpatient	80% (of the **recognized charge**) per visit
Maternity and related newborn care	
Inpatient	80% (of the **recognized charge**) per admission

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Eligible health services*	
Mental health treatment - inpatient	
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **recognized charge**) per admission
Mental health treatment - outpatient	
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **recognized charge**) per visit
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultation	80% (of the **recognized charge**) per visit

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Eligible health services*	
Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive outpatient program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the **recognized charge**) per visit
Substance related disorders treatment - inpatient	
Inpatient **substance abuse detoxification** during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **recognized charge**) per admission

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Substance related disorders treatment - outpatient: detoxification and rehabilitation	
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation) Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **recognized charge**) per visit
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **recognized charge**) per visit
Other outpatient **substance abuse** services (includes skilled behavioral health services in the home) **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive outpatient program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the **recognized** charge) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Obesity surgery	
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	80% (of the **recognized charge**) per admission
Outpatient obesity surgery	
	80% (of the **recognized charge**) per visit

Oral and maxillofacial treatment (mouth, jaws and teeth)	
Oral and maxillofacial treatment (mouth, jaws and teeth)	Covered according to the type of benefit and the place where the service is received
Reconstructive breast surgery	
Reconstructive breast **surgery**	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery and supplies	
Reconstructive **surgery**	Covered according to the type of benefit and the place where the service is received
Transplant services facility and non-facility	
Inpatient **hospital** transplant services	80% (of the **recognized charge**) per transplant
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.
Treatment of infertility	
Basic infertility	
Basic **infertility**	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Specific therapies and tests	
Outpatient diagnostic testing	
Diagnostic complex imaging services	
	80% (of the **recognized** charge) per visit
Diagnostic lab work	
	80% (of the **recognized** charge) per visit.
Diagnostic radiological services	
	80% (of the **recognized** charge) per visit.
Chemotherapy	
	80% (of the **recognized charge**) per visit
Outpatient infusion therapy	
	80% (of the **recognized charge**) per visit
Outpatient radiation therapy	
Radiation therapy	80% (of the **recognized charge**) per visit
Short-term cardiac and pulmonary rehabilitation services	
Cardiac rehabilitation	
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received
Pulmonary rehabilitation	
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received

Short-term rehabilitation services
Short-term rehabilitation services (outpatient physical, occupational therapies) combined with Habilitation therapy services (outpatient physical, occupational therapies)
80% (of the **recognized** charge) per visit.
Short-term rehabilitation services (outpatient speech therapies) combined with Habilitation therapy services (outpatient speech therapies)
80% (of the **recognized** charge) per visit.

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Eligible health services*	
Other services	
Acupuncture	
Acupuncture	80% (of the **recognized charge**) per visit
Ambulance service	
Ground, air or water **ambulance**	80% (of the **recognized charge**) per trip
Clinical trial therapies (experimental or investigational)	
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received
Experimental or investigational treatment lifetime maximum	$10,000
Clinical trials (routine patient costs)	
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received
Prosthetic devices	
Prosthetic devices	80% (of the **recognized charge**) per item
Maximum benefit for wigs	1 every 3 years
Spinal manipulation	
Spinal manipulation	80% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- Maximums

that are listed in the first part of this schedule of benefits.

Deductible provisions

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/payment percentage** for **eligible health services** to which the **deductible** does not apply.

Individual

This is the amount you owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Copayments

Copayment

This is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services**.

Payment percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Maximum out-of-pocket limits provisions

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge/recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment**/**payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services
- Any out of pocket costs for outpatient **prescription drugs**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of 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 Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.