

Schedule of benefits

Prepared for:

Employer: State Teachers Retirement System of Ohio (STRS Ohio)
Contract number: ASA-351630-A
Plan name: 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: 3B
Plan effective date: January 1, 2022
Plan issue date: August 30, 2021

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles, copayments** 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.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
 - For the **covered services** under your medical plan, you will be responsible for the dollar amount
 - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage 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 **deductibles, copayments** 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/>

Important note:

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

Under this plan, you will:

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

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 37 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 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**.

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. Keep it with your Medical Plan Description.

Plan features

Precertification covered services reduction

(Does not apply if you are enrolled in Medicare Part A)

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**

You may have to pay an additional portion of the **recognized charge** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

Deductible

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

Deductible type	
Individual	\$2,500 per year

Deductible waiver

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

- Preventive care
- Family planning services – female contraceptives

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	
Individual	\$6,500 per year

General coverage provisions

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

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. After the amount paid for **covered services** reaches this individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. The individual **deductible** applies to a person who is enrolled for self-only coverage with no dependent coverage.

Copayment

This is a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Payment Percentage

This is the percentage of the bill you pay after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**.

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** that would apply toward the limit for you for the remainder of the year.

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

- Out-of-pocket costs for outpatient expenses including **prescription** drugs
- All costs for non-covered services which are identified in the Medical Plan Description and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Emergency room per visit **copayments** Urgent care **provider** per visit **copayments**

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

Acupuncture

Description	
Acupuncture	80% after deductible

Ambulance services

Description	
Emergency services	80% per trip after deductible
Description	
Non-emergency services	80% per trip after deductible

Applied behavior analysis

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

Autism spectrum disorder

Description	
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 disorders treatment

Coverage provided is the same as for any other illness

Description	
Inpatient services-room and board including residential treatment facility	80% per admission after deductible

Description	
Outpatient office visit to a physician or behavioral health provider	80% per visit after deductible
Physician or behavioral health provider telemedicine consultation	80% per visit after deductible
Outpatient mental health disorders telemedicine cognitive therapy consultations* by a physician or behavioral health provider	80% per visit after deductible
* 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	
Other outpatient services including: <ul style="list-style-type: none"> • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program 	80% per visit after deductible

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	
Inpatient services-room and board during a hospital stay	80% per admission after deductible

Description	
Outpatient office visit to a physician or behavioral health provider	80% per visit after deductible
Physician or behavioral health provider telemedicine consultation	80% per visit after deductible
Outpatient telemedicine cognitive therapy consultations* by a physician or behavioral health provider	80% per visit after deductible
* 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	
Other outpatient services including: <ul style="list-style-type: none"> Behavioral health services in the home Partial hospitalization treatment Intensive outpatient program 	80% per visit after deductible

Clinical trials

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

Durable medical equipment (DME)

Description	
DME	80% per item after deductible

Emergency services

Description	
Emergency room	\$150 then the plan pays 80% per visit after deductible

Emergency services important note:

Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. 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	
Inpatient	100% per admission, no deductible applies
Outpatient	100% per visit, no deductible applies

Voluntary sterilization for males

Description	
Outpatient	80% per visit after deductible

Abortion

Description	
Outpatient	80% per visit after deductible

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	
PT, OT therapies	80% per visit after deductible

Speech therapy (ST)

Description	
ST	80% per visit after deductible

Home health care

A visit is a period of 4 hours or less

Description	
Home health care	80% per visit after deductible

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	
Inpatient services - room and board	80% per admission after deductible

Description	
Outpatient services	80% per visit after deductible

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	
Inpatient services – room and board	80% per admission after deductible

Infertility services

Basic infertility

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

Maternity and related newborn care

Includes complications

Description	
Inpatient services – room and board	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 certificate. It will give you more information about coverage for maternity care under this plan.

Obesity surgery

Description	
Inpatient services – room and board	80% per admission after deductible

Description	
Outpatient services	80% per visit after deductible

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

Outpatient surgery

Description	
At hospital outpatient department	80% after deductible

Physician and specialist services

Physician - general or family practitioner

Description	
Physician office hours (not surgical, not preventive) First 2 visits per calendar year Visits thereafter in the same calendar year	\$20 then the plan pays 100% per visit, no deductible applies 80% per visit after deductible
Physician surgical services	80% per visit after deductible
Allergy injections, testing, and treatment	80% per visit after deductible

Description	
Physician telemedicine consultation First 2 visits per calendar year Visits thereafter in the same calendar year	\$20 then the plan pays 100% per visit, no deductible applies 80% per visit after deductible

Description	
Physician visit during inpatient stay	80% per visit after deductible

Specialist

Description	
Specialist office hours (not surgical, not preventive)	80% per visit after deductible
Specialist surgical services	80% per visit after deductible
Allergy injections, testing, and treatment	80% per visit after deductible

Description	
Specialist telemedicine consultation	80% per visit after deductible

All other services not shown above

Description	
All other services	80% per visit after deductible

Preventive care

Description	
Preventive care services	100% per visit, no deductible applies
Breast feeding counseling and support	100% per visit, no deductible 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 physician services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 3 years 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: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no deductible 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 deductible applies
Counseling for obesity, healthy diet	100% per visit, no deductible 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 deductible applies
Counseling for sexually transmitted infection visit limit	2 visits/calendar year
Counseling for tobacco cessation	100% per visit, no deductible applies
Counseling for tobacco cessation visit limit	8 visits/calendar year
Family planning services (female contraception counseling)	100% per visit, no deductible 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 physician during an office visit	100%, no deductible applies

Description	
Immunizations	100%, no deductible 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 physician
Routine cancer screenings	100% per visit, no deductible 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 physician or see the <i>Contact us</i> section
Routine lung cancer screening	100% per visit, no deductible 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 deductible 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
Well woman GYN exam	100% per visit, no deductible 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 eight hours equals one shift

Description	
Outpatient services	80% per visit after deductible

Prosthetic devices

Description	
Prosthetic devices	80% per item after deductible
Maximum benefit for wigs	1 every 3 years

Reconstructive surgery and supplies

Including breast surgery

Description	
Surgery and supplies	Covered based on type of service and where it is received

Short-term rehabilitation services

Cardiac Rehabilitation

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

Pulmonary Rehabilitation

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

Cognitive Rehabilitation

Description	
Cognitive Rehabilitation	Covered based on type of service and where it is received

Physical and occupational therapies

Description	
At the physician office	80% per visit after deductible

Speech therapy (ST)

Description	
At the physician office	80% per visit after deductible

Spinal Manipulation

Description	
At the physician office	80% per visit after deductible

Skilled nursing facility

Description	
Inpatient services - room and board	80% per admission after deductible
Other inpatient services and supplies	80% per admission after deductible

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

Diagnostic complex imaging services

Description	
	80% per visit after deductible

Diagnostic lab work

Description	
	80% per visit after deductible

Diagnostic x-ray and other radiological services

Description	
	80% per visit after deductible

Therapies

Chemotherapy

Description	
Chemotherapy services	80% per visit after deductible

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

Description	GCIT-designated facility/provider
Services and supplies	Covered based on type of service and where it is received

Infusion

Outpatient services

Description	
	80% per visit after deductible

Radiation therapy

Description	
Radiation therapy	80% per visit after deductible

Respiratory therapy

Description	
Respiratory therapy	80% per visit after deductible

Transplant services

Description	
Inpatient services and supplies	80% per transplant after deductible
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	
Urgent care facility	\$40 then the plan pays 80% per visit after deductible

Walk-in clinic

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

Description	
Non-emergency services First 2 visits per calendar year Visits thereafter in the same calendar year	\$20 then the plan pays 100% per visit, no deductible applies 80% per visit after deductible
Preventive immunizations	100% per visit, no deductible applies
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 physician
Screening and counseling services	100% per visit, no deductible applies
Screening and counseling limits	See the Preventive care services section of the SOB