Pace University
2025 Medical Plan Comparison Chart

| | Aetna 2025 Plans | | |
|---|---|---|---|
| **Plan Name** | **Network Core Plan** | **Choice PPO** | |
| **Network** | **Open Access Aetna Select (formerly Elect Choice)** | **Open Access Choice POS II (formerly Managed Choice)** | |
| | **In Network** | **In Network** | **Out of Network** |
| **Deductible** | $250 / $500 | $850/$1,700 | $2,500/$5,000 |
| **Coinsurance** | Covered 100% | 85% | 60% |
| **Out of Pocket Maximum** | $2,000/$4,000 | $2,000/$4,000 | $6,000/$12,000 |
| **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 |
| **PCP Office Visits** | $30 copay | $30 copay | Deductible & 70% Coinsurance |
| **Specialist Visits** | $50 copay | $50 copay | Deductible & 70% Coinsurance |
| **Telehealth Connection Services** | $30 copay | $30 copay | Not covered |
| **OB/GYN Visits** | Office Visit - $30/$50 copay Preventive care - Covered 100% | Office Visit - $30/$50 copay Preventive care - Covered 100% | Deductible and 70% Coinsurance |
| **Preventive Care / Physical Exams/Immunizations** | 100% | 100% | Deductible & 70% Coinsurance |
| **Well Child Exams (through age 18)** | 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 | Deductible & Coinsurance; 1 routine exam covered every 24 months; Separate vision plan through Aetna Vision |
| **Lab and X-ray** | 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% | 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 & 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 & Coinsurance (Emergency Use only) | Deductible & 85% Coinsurance (Emergency Use only) |
| **Emergency Room** | $100 per visit; Waived if admitted | $100 per visit; Waived if admitted | $100 per visit; Waived if admitted |
| **Urgent Care** | $30 per visit | $30 per visit | $30 per visit |
| **Hospitalization** | 100% after deductible | Deductible & Coinsurance | Deductible & Coinsurance |
| **Outpatient Surgery** | 100% after deductible | Deductible & Coinsurance | Deductible & Coinsurance |
| **Inpatient Mental Health** | 100% after deductible | Deductible & Coinsurance | Deductible & Coinsurance |
| **Outpatient Mental Health** | Office Visit - $30 copay Outpatient Facility - 100% | Office Visit - $30 copay Outpatient Facility - 100% | Deductible & 70% Coinsurance |
| **Substance Abuse** | 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 |

This chart is intended only to provide a summary of information. If there are any discrepancies between the information herein, and the Plan documents, the Plan documents will always govern.

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| **Inpatient Physical Therapy** | 100%; after deductible<br>60 days maximum per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities | Deductible & Coinsurance;<br>60 days maximum per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities | Deductible & Coinsurance;<br>60 days maximum per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities |
| **Outpatient Physical Therapy** | $50 Copay<br>Limited to 90 visits per year. Unlimited for early intervention services from birth to age 3.<br>Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy | $50 Copay<br>Limited to 90 visits per year. Unlimited for Early Intervention Services from birth to age 3.<br>Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy | Deductible & 70% Coinsurance<br>Limited to 90 visits per year. Unlimited for Early Intervention Services from birth to age 3.<br>Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy |
| **Hospice Care** | 100% after deductible | Deductible & Coinsurance | Deductible & Coinsurance |
| **Home Health Care (includes Outpatient Private Duty Nursing)** | 100%<br>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<br>Home health care services include private duty nursing;<br>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<br>Home health care services include private duty nursing;<br>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% after deductible<br>Limited to 60 days per year<br>Includes Rehabilitation Hospital and Sub-Acute Facilities | Deductible & Coinsurance<br>Limited to 60 days per year<br>Includes Rehabilitation Hospital and Sub-Acute Facilities | Deductible & Coinsurance<br>Limited to 60 days per year<br>Includes Rehabilitation Hospital and Sub-Acute Facilities |
| **TMJ- Surgical and Non Surgical - Always excludes appliances & orthodontic treatment. Subject to medical necessity.** | Office Visit - $30/$50 copay<br>Inpatient and Outpatient facility - 100% after deductible | Office Visit - $30/$50 copay<br>Inpatient and Outpatient facility - Deductible & Coinsurance | Office Visit - Deductible & 70% Coinsurance<br>Inpatient and Outpatient facility - Deductible & Coinsurance |
| **Infertility** | Office Visit - $30/$50 copay<br>Inpatient & Outpatient Facility - 100% after deductible;<br>Comprehensive (includes artificial insemination) - Unlimited maximum<br>Advanced Infertility ( IV, ZIFT, GIFT) - Unlimited maximum | Office Visit - $30/$50;<br>Inpatient & Outpatient Facility - Deductible & Coinsurance<br>Comprehensive (includes artificial insemination) - Unlimited maximum<br>Advanced Infertility ( IV, ZIFT, GIFT) - Unlimited maximum | Deductible & Coinsurance;<br>Comprehensive (includes artificial insemination) - Unlimited maximum<br>Advanced Infertility ( IV, ZIFT, GIFT) - Unlimited maximum |
| **Abortion** | Office Visit - $30/$50 copay<br>Inpatient & Outpatient Facility - 100% after deductible | Office Visit - $30/$50 copay<br>Inpatient & Outpatient Facility - Deductible & Coinsurance | Office Visit - Deductible & 70% Coinsurance<br>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%;<br>Unlimited maximum | Deductible & Coinsurance;<br>Unlimited maximum | Deductible & Coinsurance;<br>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 |