YESHIVA UNIVERSITY
Effective Date: 01-01-2027
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PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.	
Deductible (per calendar year)	$1,500 per Individual $3,750 per Family
You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.	
Member coinsurance	You pay 20%
Applies to all expenses except as noted.	
Out-of-pocket limit (per calendar year)	$4,000 per Individual $8,000 per Family
Pharmacy expenses count toward the out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.	
Lifetime maximum	
Unlimited except where otherwise indicated.	
Primary care physician selection	Encouraged
Referral requirement	Not required
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.	
Virtual care consultations - You can access covered services for virtual care visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of virtual care providers. You'll also find more about your options, including cost share amounts.	
CVS VIRTUAL CARE	**IN-NETWORK**
CVS Health Virtual Care (VC) - general medicine	Covered 100%; no deductible
CVS Health Virtual Care (VC) - mental health	Covered 100%; no deductible
PREVENTIVE CARE	**IN-NETWORK**
Routine adult physical exams/ immunizations	Covered 100%; no deductible
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	
Routine well child exams/immunizations	Covered 100%; no deductible
• 7 exams in the first 12 months • 3 exams from age 13 months to 24 months • 3 exams from age 25 months to 36 months • 1 exam every 12 months thereafter until age 22	
Routine gynecological care exams	Covered 100%; no deductible
1 exam and pap smear per year, includes related fees.	
Breast cancer screening	Covered 100%; no deductible
Recommended: One per year for members age 40 and over	

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Women's health	Covered 100%; no deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	
Pre-natal maternity	Covered 100%; no deductible
Routine digital rectal exam	Covered 100%; no deductible
Recommended: For members age 40 and over	
Prostate-specific antigen test	Covered 100%; no deductible
Recommended: For members age 40 and over	
Colorectal cancer screening	Covered 100%; no deductible
Recommended: For members age 45 and over	
Routine eye exams	$20 copay; no deductible
1 routine exam per 24 months.	
Routine hearing screening	Covered 100%; no deductible
Medications	Certain over-the-counter preventive medications covered 100% in network.
PHYSICIAN SERVICES	**IN-NETWORK**
Office visits to primary care physician (PCP)	$25 office visit copay; no deductible
Includes services of an internist, general physician, family practitioner or pediatrician.	
Telehealth consultation with non-specialist	$25 office visit copay; no deductible
Specialist office visits	$50 office visit copay; no deductible
Telehealth consultation with specialist	$50 office visit copay; no deductible
Hearing exams	Not Covered
Walk-in clinics	$25 copay; no deductible **Designated Walk-in clinics** Covered 100%; no deductible
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic x-ray (Other than complex imaging services)	20%; no deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic laboratory	20%; no deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic complex imaging	20%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	

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EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent care provider	$50 office visit copay; no deductible
Non-urgent use of urgent care provider	Not Covered
Emergency room Copay waived if admitted	$250 copay; no deductible
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	$250 copay; no deductible
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient coverage When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible
Inpatient maternity coverage (includes delivery and postpartum care) When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible
Outpatient hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	20%; after deductible
Outpatient surgery - hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	20%; after deductible
Outpatient surgery - freestanding facility When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible
Mental health office visits	$25 copay; no deductible
Mental health telehealth consultations	$25 office visit copay; no deductible
Other mental health services When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	20%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible
Residential treatment facility When admitted into a facility, cost sharing amount counts toward all covered benefits received.	20%; after deductible
Substance abuse office visits	$25 copay; no deductible
Substance abuse telehealth consultations	$25 office visit copay; no deductible

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Other substance abuse services	20%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
THERAPY SERVICES	**IN-NETWORK**
Spinal manipulation therapy	$25 copay; no deductible
Outpatient rehabilitative physical therapy Limited to 60 visits per year	$25 copay; no deductible
Outpatient rehabilitative speech therapy Limited to 30 visits per year	$25 copay; no deductible
Outpatient rehabilitative occupational therapy Limited to 30 visits per year	$25 copay; no deductible
Habilitative physical therapy	20%; after deductible
Habilitative occupational therapy	20%; after deductible
Habilitative speech therapy	20%; after deductible
Autism related physical therapy	20%; after deductible
Autism related occupational therapy	20%; after deductible
Autism related speech therapy	20%; after deductible
Autism related behavioral therapy	$25 copay; no deductible
These benefits are combined with outpatient mental health visits	
Autism related applied behavior analysis	20%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit	
OTHER SERVICES	**IN-NETWORK**
Skilled nursing facility	20%; after deductible
Limited to 60 days per year When admitted into a facility, cost sharing amount counts toward all covered benefits received.	
Home health care	20%; after deductible
Limited to 200 visits per year Private duty nursing not included. Limited to three visits per day by staff from a home health care agency.	
Hospice care - inpatient	20%; after deductible
When admitted into a facility, cost sharing amount counts toward all covered benefits received.	
Hospice care - outpatient	20%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Private duty nursing	Not Covered
Durable medical equipment	20%; after deductible
Diabetic supplies	
• If not covered under the prescription drug benefit	You pay your PCP visit cost sharing amount
• If covered under the prescription drug benefit	Applicable prescription drug cost sharing amount applies
Infusion therapy - home/office	$50 copay; no deductible
Infusion therapy - outpatient hospital/freestanding facility	20%; after deductible

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Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. $50 copay; no deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.
Transplants	20%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.
Bariatric surgery	20%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Acupuncture	$25 copay; no deductible
FAMILY PLANNING	**IN-NETWORK**
Basic infertility	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for artificial insemination and the diagnosis and treatment of the underlying cause of infertility.	
Advanced Reproductive Technology (ART)	Your cost sharing amount depends on the type of service and where you receive it.
ART coverage is limited to ovulation induction (OI) only. Maximum applies to all procedures covered by any of our plans except where prohibited by law.	
Fertility preservation	Not Covered
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.
Tubal ligation	Covered 100%; no deductible
GENERAL PROVISIONS	
Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

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The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.
• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

*****This plan document provides you with an overview of some of your benefits and your cost share obligations. This information is for illustrative purposes ONLY. This document is not an official document and may differ from your Certificate of Coverage (COC), which is your official document. Refer to your COC for your coverage and services and any obligations on your part.**

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