Yeshiva University
Effective Date: 01-01-2025
Aetna Choice® POS II -- ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-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	$4,500 per Individual $11,250 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. 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%	You pay 40%
Applies to all expenses except as noted.		
Out-of-pocket limit (per calendar year)	$4,000 per Individual $10,000 per Family	$10,500 per Individual $25,500 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-		

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type	Aetna Standard Plan	
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Generic drugs		
Retail	$7.50 copay	Not Covered
Mail order		

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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.

‡ $OO PHGLFDO DQG KRVSLWDO VHUYLFHV QRW VSHFLILFDOO\ FRYHUH
documents.
‡ &RVPHWLF VXUJHU\ LQFOXGLQJ EUHDVW UHGXFWL
‡ &XVWRGLDO FDUH
‡ 'HQWDO FDUH DQG GHQWDO ;-rays.
‡ 'RQRU HJJ UHWULHYDO
‡ ([SHULPHQWDO DQG LQYHVWLJDWLRQDO SURFHGXUHV H[FHSW IRU F
for members participating in a cancer clinical trial.
‡ +HDULQJ aids
‡ +RPH ELUWKV
‡ ,PPXQL]DWLRQV IRU WUDYHO RU ZRUN H[FHSW ZKHUH PHGLFDOO\ Q
‡ Implantable drugs and certain injectable drugs including injectable infertility drugs.
‡ ,QIHUWLOLW\ VHUYLFHV LQFOXGLQJ DUWLILFLDO LQVHPLQDWLRQ D(
ICSI and other related services, unless specifically listed as covered in your plan documents.
‡ /RQJ-term rehabilitation therapy.
‡ 1RQ-medically necessary services or supplies.
‡ 2XWSDWLHQW SUHVFULSWLRQ GUXJV H[FHSW IRU WUHDWPHQW RI G
the-counter medications (except as provided in a hospital) and supplies.
‡ 5DGLDO NHUDWRWRP\ RU UHODWHG SURFHGXUHV
‡ 5HYHUVDO RI VWHULOL]DWLRQ
‡ 6HUYLFHV IRU WKH WUHDWPHQW RI VH[XDO G\VIXQFWLRQ HQKDQFHP
prescription drugs.

‡ 7KHUDS\ RU UHKDELOLWDWLRQ RWKHU WKDQ WKRVH OLVWHG DV FR