



YESHIVA UNIVERSITY
Effective Date: 01-01-2024
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PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED



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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
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.	
Telehealth consultations for non-emergency services through a walk-in clinic	Your cost sharing amount depends on the type of service and where you receive it.
	Designated Walk-in clinics
	Covered 100%; no deductible
We pay telehealth screenings and counseling services from a walk-in-clinic as a preventive care benefit.	
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.	
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	\$250 copay; no deductible
Copay waived if admitted	



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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	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.	
Inpatient maternity coverage (includes delivery and postpartum care)	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.	
Outpatient hospital	20%; after deductible
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.	
Outpatient surgery - hospital	20%; after deductible
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.	
Outpatient surgery - freestanding facility	20%; after deductible
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.	
MENTAL HEALTH SERVICES	IN-NETWORK
Inpatient	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.	
Mental health office visits	\$25 copay; no deductible
Mental health telehealth consultations	\$25 office visit copay; no deductible
Other mental health 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.	
SUBSTANCE ABUSE	IN-NETWORK
Inpatient	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.	
Residential treatment facility	20%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Substance abuse office visits	\$25 copay; no deductible
Substance abuse telehealth consultations	\$25 office visit copay; no deductible
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	



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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
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.	
Comprehensive infertility services	20%; after deductible
Artificial insemination and ovulation induction	
Advanced Reproductive Technology (ART)	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.
Tubal ligation	Covered 100%; no deductible
PHARMACY	IN-NETWORK
Pharmacy plan type	Aetna Standard Open Formulary
Prescription drug out-of-pocket limit	



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The following is a list of services and supplies that are 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.