Schedule of Benefits

Employer: **Yale University**

ASA: 877076

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For: Aetna Choice POS II with HSA

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$1,500	$1,500
Family Deductible*	$3,000	$3,000

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible**

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **network** and **out of network** expenses combined**:** $4,000.

Family Maximum Out of Pocket Limit:

- For **network** and **out of network** expenses combined**:** $8,000.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Wellness Benefit		
Routine Physical Exams Adults only. Includes coverage for immunizations.	80% per exam No **deductible** applies.	Not Covered
Maximum Exams per 24 consecutive month period		
Adults age 18 to 65	1 exam	Not Covered
Maximum Exams per 12 consecutive month period		
Adults age 65 and over	1 exam	Not Covered
Well Child Exams Includes coverage for immunizations	80% per exam No **deductible** applies.	Not Covered
Maximum Exams per 24 consecutive month period Under age 2		
first 12 months of life	7 exams	Not Covered
13th-24th months of life	2 exams	Not Covered
Maximum Exams per 12 consecutive month period For age 2 to 18	1 exam	Not Covered
Routine Gynecological Exam	80% per exam No **deductible** applies.	50% per exam No **deductible** applies
Maximum exams per Calendar Year	1 exam	1 exam

Hearing Exam	80% per exam No **deductible** applies.	50% per exam No **deductible** applies
Maximum exams per 24 month period	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings		
Routine Mammography For covered females age 40 and over.	80% per test No **deductible** applies.	50% per test No **deductible** applies
Maximum tests per Calendar Year	1 test	1 test
Prostate Specific Antigen Test For covered males age 40 and over.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test	1 test
Routine Digital Rectal Exam For covered males age 40 and over.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test	1 test
Routine Pap Smears	80% per test No **deductible** applies.	50% per test No **deductible** applies
Maximum tests per Calendar Year	1 test	1 test
Fecal Occult Blood Test	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test	1 test

Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test
Double Contrast Barium Enema *(DCBE)* Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 10 consecutive year period	1 test	1 test

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Vision Care		
Eye Examinations including refraction	80% per exam No **deductible** applies.	50% per exam No **deductible** applies
Maximum Benefit per 12 consecutive month period	1 exam	1 exam

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Specialist Office Visits *All Specialists except those specifically listed in this schedule.*	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

Physician Office Visits-Surgery	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Walk-in Clinics Non-Emergency Visit	80% per visit after Calendar Year **deductible**	Not Covered
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**
Allergy Testing and Treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Allergy Injections	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Immunizations (when not part of the physical exam)	80% per visit No **deductible** applies.	50% per visit after Calendar Year **deductible**
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
Hospital Emergency Facility	80% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**
Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	100%	50% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing (except complex imaging services)	80% per procedure No **deductible** applies	50% per procedure No **deductible** applies
Complex Imaging Services		
Complex Imaging	80% per test after Calendar Year **deductible**	50% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Performed at a Hospital Outpatient Facility	80% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	80% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	90 days	90 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits	120 visits
Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Hospice Outpatient Visits	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Artificial Insemination Maximum Benefit*	4 courses of treatment per lifetime*	4 courses of treatment per lifetime*
Ovulation Induction Maximum Benefit*	4 courses of treatment per lifetime*	4 courses of treatment per lifetime*
Maximum per lifetime*	$15,000*	$15,000*
*Does not apply toward the plan payment percentage. limit		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
Mental Disorders	80% per admission after the Calendar Year **deductible**	50% per admission after the Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders		
Mental Disorders	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Alcoholism and Substance Abuse		
Inpatient Treatment	80% per admission after the Calendar Year **deductible**	50% per admission after the Calendar Year **deductible**
Outpatient Treatment of Alcoholism and Substance Abuse		
Outpatient Treatment	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical and Non Surgical		
Outpatient Obesity Treatment (non surgical)	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Related Outpatient Morbid Obesity Surgery Services	80% per service after Calendar Year **deductible**	50% per service after Calendar Year **deductible**
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient) This maximum benefit includes services provided or administered by Aetna or any affiliated company of Aetna	Unlimited	Unlimited

Important Notice:
If the overall plan Maximum Benefit shown in the *Schedule of Benefits* is exhausted, no additional **morbid obesity** surgical treatment expenses are covered.

Transplant Services Facility and Non-Facility Expenses

Your coverage will be considered network if provided at a participating Institutes of Excellence facility only. Your coverage will be considered out-of-network if it is not provided at an Institutes of Excellence facility.

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Facility Expenses	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Physician Services (including office visits)	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Ground, Air or Water Ambulance	80% per trip after Calendar Year **deductible**	80% per trip after Calendar Year **deductible**
Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	50% per item after the Calendar Year **deductible**
Maximum Benefit per Calendar Year	$5,000	$5,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prescription Drugs		
Contraceptive Coverage and Diabetic Supplies and Insulin	80% per prescription or refill, after the Calendar Year **deductible**	50% per prescription or refill, after the Calendar Year **deductible**
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Infusion Therapy	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Radiation Therapy	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational and Speech Therapy combined and Spinal Manipulation	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Generic and Brand-Name Prescription Drugs		
For each 30 day supply	80% of the **negotiated charge**	50% of the **recognized charge**
For more than a 30 day supply but less than a 91 day supply	80% of the **negotiated charge**	Not Applicable

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Individual Deductible

The Individual **deductible** is the amount of **network** or **out of network covered expenses** you must incur in a Calendar Year before benefits are paid. For purposes of this Plan, an individual means a single covered person enrolled for self only coverage.

Family Deductible

The Family **deductible** is the amount of **network** or **out of network covered expenses** that you and your covered dependents must incur in a Calendar Year before benefits are paid during the Calendar Year for any family members. For purposes of this Plan, a family means a covered person enrolled with one or more dependents

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Payment/Maximum Out-of-Pocket Limit

This plan has an Individual and Family **Payment/Maximum Out-of-Pocket Limit.** For purposes of the provision an individual means a person enrolled for self only coverage with no dependent coverage and a Family means a person enrolled with one or more dependents.

The **Payment/Maximum Out-of-Pocket Limit** applies to both network and out -of-network benefits. **Covered expenses** applied to the out-of-network **Payment/Maximum Out-of-Pocket limit** will be applied to satisfy the in-network **Payment/Maximum Out-of-Pocket limit** and **covered expenses** applied to the in-network **Payment/Maximum Out-of-Pocket limit** will be applied to satisfy the out-of-network **Payment/Maximum Out-of-Pocket limit**.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Any **covered expenses** which are payable by **Aetna** at 50%,
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*), and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Maximum Benefit Provisions

Calendar Year Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit will not deny benefits for certain covered expenses in any one Calendar Year.

The Calendar Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

The Calendar Year maximum benefit applies to the medical and **prescription drug** expense coverage described in this Booklet.

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A $200 benefit reduction will be applied separately to certain designated precedures covered under the outpatient precertification program.
- A $500 benefit reduction will be applied separately to each type of expense shown in the List of Services and Supplies Which Require Precertification.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.