

Schedule of Benefits

Employer: Yale University
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Booklet Base: 3

For: Aetna Choice POS II with Alternate Prescription Drug - Clerical, Technical, Service and Maintenance Staff

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* | None | \$250 |
| Family Deductible* | None | \$750 |

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

Plan Payment Limit excludes plan **deductible, copayments and precertification** penalties

Individual Payment Limit:

- For **network** expenses: None.
- For **out-of-network** expenses: \$1,000.

Family Payment Limit:

- For **network** expenses: None.
- For **out-of-network** expenses: \$3,000.

| | | |
|---|-----------|-----------|
| <i>Lifetime Maximum Benefit per person</i> | Unlimited | Unlimited |
|---|-----------|-----------|

Payment Percentages listed in the Schedule below reflects the Plan Payment Percentage This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining payment percentage. 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. | \$ 5 exam copay then the plan pays 100% 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 | \$5 exam copay then the plan pays 100% 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 | \$5 exam copay then the plan pays 100% No deductible applies. | 70% per exam after Calendar Year deductible |
| Maximum exams per Calendar Year | 1 exam | 1 exam |
| Hearing Exam | \$5 exam copay then the plan pays 100% No deductible applies. | 70% per exam after Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|--|
| <i>Routine Cancer Screenings</i> | | |
| <i>Routine Mammography</i> For covered females age 40 and over. | 100% per test No deductible applies. | 70% per test after Calendar Year deductible |
| Maximum tests per Calendar Year | 1 test | 1 test |
| <i>Prostate Specific Antigen Test</i> 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 |
| <i>Routine Digital Rectal Exam</i> 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 |
| <i>Routine Pap Smears</i> | 100% per test No deductible applies. | 70% per test after Calendar Year deductible |
| Maximum tests per Calendar Year | 1 test | 1 test |
| <i>Fecal Occult Blood Test</i> | 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 |
| <i>Sigmoidoscopy</i> 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. |
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|---|--------|--------|
| Maximum Tests per 5 consecutive year period | 1 test | 1 test |
|---|--------|--------|

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|---------------------------------------|--|--|
| 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. |
|---------------------------------------|--|--|

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|--|--------|--------|
| Maximum Tests per 10 consecutive year period | 1 test | 1 test |
|--|--------|--------|

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|--|
| Vision Care | | |
| Eye Examinations including refraction | \$5 exam copay then the plan pays 100% | 70% per exam after Calendar Year deductible |
| | 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 | 100% per visit after Calendar Year deductible | 70% per visit after Calendar Year deductible |
| Specialist Office Visits <i>All Specialists except those specifically listed in this schedule.</i> | \$5 visit copay after Calendar Year deductible then the plan pays 100% | 70% per visit after Calendar Year deductible |
| Physician Office Visits-Surgery | \$5 per visit copay after Calendar Year deductible then the plan pays 100% | 70% per visit after Calendar Year deductible |

| | | |
|--|--|--------------------|
| Walk-In Clinics Non-Emergency Visit | \$5 visit copay then the plan pays 100% | Not Covered |
| | No deductible applies. | |

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|--|--|--|
| <i>Physician Services for Inpatient Facility and Hospital Visits</i> | \$0 visit copay after Calendar Year deductible then the plan pays 100% | 70% per visit after Calendar Year deductible |
| <i>Administration of Anesthesia</i> | 100% per procedure after Calendar Year deductible | 70% per procedure after Calendar Year deductible |
| <i>Allergy Testing and Treatment</i> | 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. |
| <i>Allergy Injections</i> | 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. |
| <i>Immunizations (when not part of the physical exam)</i> | 100% per visit No deductible applies. | 70% per visit after Calendar Year deductible |
| <i>Prenatal Visits</i> | 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 |
| <i>Emergency Medical Services</i> | | |
| <i>Hospital Emergency Facility</i> | \$50 copay per visit then the plan pays 100% No deductible applies | \$50 deductible per visit then the plan pays 100% No deductible applies |
| <i>Non-Emergency Care in a Hospital Emergency Room</i> | Not covered | Not covered |

Important Notice:

A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your deductible is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

| Urgent Care Services | | |
|---|---|---|
| Urgent Medical Care <i>(at a non-hospital free standing facility)</i> | \$25 copay per visit then the plan pays 100% | 70% after Calendar Year deductible |
| | No deductible applies | |

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|--|-------------|-------------|
| Non-Urgent Use of Urgent Care Provider <i>(at a non-hospital free standing facility)</i> | Not covered | Not covered |
|--|-------------|-------------|

Important Notice:

A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**. If you are admitted to a **hospital** as an inpatient immediately following a visit to an **urgent care provider**, this **copay/deductible** is waived.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|----------------|-----------------------|
| Outpatient Diagnostic and Preoperative Testing | | |

| | | |
|--|--|---|
| Diagnostic and Preoperative Testing <i>(except complex imaging services)</i> | 100% per procedure after Calendar Year deductible | 70% per procedure after Calendar Year deductible |
|--|--|---|

| Complex Imaging Services | | |
|---------------------------------|---|--|
| Complex Imaging | 100% per test after Calendar Year deductible | 70% per test after Calendar Year deductible |

| Diagnostic Laboratory Testing | | |
|--------------------------------------|--|---|
| Diagnostic Laboratory Testing | 100% per procedure after Calendar Year deductible | 70% per procedure after Calendar Year deductible |

| Diagnostic X-Rays (except Complex Imaging Services) | | |
|--|--|---|
| Performed at a Hospital Outpatient Facility | 100% per procedure after Calendar Year deductible | 70% per procedure after Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---------------------------|----------------|-----------------------|
| Outpatient Surgery | | |

| | | |
|---------------------------|--|---|
| Outpatient Surgery | 100% per procedure after Calendar Year deductible | 70% per procedure after Calendar Year deductible |
|---------------------------|--|---|

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|--|
| <i>Inpatient Facility Expenses</i> | | |
| <i>Birth Center</i> | 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. |
| <i>Hospital Facility Expenses</i> | 100% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible |
| Room and Board (including maternity) | | |
| Other than Room and Board | 100% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible |
| <i>Skilled Nursing Inpatient Facility</i> | 100% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible |
| Maximum Days per Calendar Year | 90 days | 90 days |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|---|
| <i>Specialty Benefits</i> | | |
| <i>Home Health Care (Outpatient)</i> | 100% per visit after the Calendar Year deductible | 70% per visit after the Calendar Year deductible |
| Maximum Visits per Calendar Year | 120 visits | 120 visits |
| <i>Private Duty Nursing (Outpatient)</i> | 100% per visit after the Calendar Year deductible | 70% per visit after the Calendar Year deductible |
| <i>Hospice Benefits</i> | | |
| <i>Hospice Care - Facility Expenses</i> (Room & Board) | 100% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible |
| <i>Hospice Care - Other Expenses during a stay</i> | 100% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible |
| <i>Hospice Outpatient Visits</i> | 100% per visit after Calendar Year deductible | 70% per visit after Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|--|--|
| <i>Infertility Treatment</i> | | |
| <i>Basic Infertility Expenses</i> 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. |
| <i>Comprehensive Infertility Expenses</i> | Payable in accordance with the type of expense incurred and the place where service is provided. | Not Covered |
| Artificial Insemination Maximum Benefit* | 6 courses of treatment per lifetime* | Not Covered |
| Ovulation Induction Maximum Benefit* | 6 courses of treatment per lifetime* | Not Covered |
| Maximum per lifetime* | \$15,000* | Not Covered |
| *Does not apply toward the plan payment percentage. limit | | |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|---|
| <i>Inpatient Treatment of Mental Disorders</i> | | |
| <i>Mental Disorders</i> | 100% per admission after the Calendar Year deductible | 70% per admission after the Calendar Year deductible |
| <i>Outpatient Treatment Of Mental Disorders</i> | | |
| <i>Mental Disorders</i> | \$5 per visit copay after Calendar Year deductible then the plan pays 100% | 70% per visit after the Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|---|
| <i>Inpatient Treatment of Alcoholism and Substance Abuse</i> | | |
| <i>Inpatient Treatment</i> | 100% per admission after the Calendar Year deductible | 70% per admission after the Calendar Year deductible |
| <i>Outpatient Treatment of Alcoholism and Substance Abuse</i> | | |
| <i>Outpatient Treatment</i> | \$5 per visit copay after the Calendar Year deductible then the plan pays 100% | 70% per visit after the Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|--|---|
| <i>Obesity Treatment Surgical and Non Surgical</i> | | |
| <i>Outpatient Obesity Treatment (non surgical)</i> | 100% per visit after the Calendar Year deductible | 70% per visit after the Calendar Year deductible |
| <i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i> | 100% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible |
| <i>Related Outpatient Morbid Obesity Surgery Services</i> | 100% per service after Calendar Year deductible | 70% per service after Calendar Year deductible |
| Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient) | Unlimited | Unlimited |
| This maximum benefit includes services provided or administered by Aetna or any affiliated company of Aetna | | |

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 |
|--|--|---|---|
| <i>Facility Expenses</i> | 100% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible |
| <i>Physician Services (including office visits)</i> | 100% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|--|--|
| <i>Other Covered Health Expenses</i> | | |
| <i>Acupuncture</i> | 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. |

| | | |
|---|--|---|
| <i>Ground, Air or Water Ambulance</i> | 100% per trip after Calendar Year deductible | 100% per trip after Calendar Year deductible |
| <i>Durable Medical and Surgical Equipment</i> | 100% per item after the Calendar Year deductible | 70% per item after the Calendar Year deductible |
| Maximum Benefit per Calendar Year | \$5,000 | \$5,000 |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|--|--|
| <i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i> | 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. |

| <i>Prescription Drugs</i> | | |
|--|---|--|
| Contraceptive Coverage and Diabetic Supplies and Insulin | 100% per prescription or refill, after the Calendar Year deductible | 70% per prescription or refill, after the Calendar Year deductible |

| | | |
|---------------------------|--|--|
| <i>Prosthetic Devices</i> | 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 |
|-----------------------------|---------|----------------|
| <i>Outpatient Therapies</i> | | |

| | | |
|---------------------|---|--|
| <i>Chemotherapy</i> | 100% per visit after Calendar Year deductible | 70% per visit after Calendar Year deductible |
|---------------------|---|--|

| | | |
|-------------------------|---|--|
| <i>Infusion Therapy</i> | 100% per visit after Calendar Year deductible | 70% per visit after Calendar Year deductible |
|-------------------------|---|--|

| | | |
|--------------------------|---|--|
| <i>Radiation Therapy</i> | 100% per visit after Calendar Year deductible | 70% per visit after Calendar Year deductible |
|--------------------------|---|--|

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|--|
| <i>Short Term Outpatient Rehabilitation Therapies</i> | | |
| <i>Outpatient Physical, Occupational and Speech Therapy combined and Spinal Manipulation</i> | \$5 per visit copay after Calendar Year deductible then the plan pays 100% | 70% per visit after the Calendar Year deductible |

Pharmacy Benefit

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|----------------------------------|----------------------------------|
| Prescription Drug Calendar Year Deductible | \$200 Individual \$600 Family | \$200 Individual \$600 Family |

Prescription Drug Calendar Year Deductible

The individual **prescription drug** Calendar Year **deductible** applies separately to you and each of your covered dependents. The family **prescription drug** Calendar Year **deductible** applies to you and your covered dependents combined. After **prescription drug covered expenses** reach the **prescription drug** Calendar Year **deductible**, the plan will begin to pay benefits for **prescription drug covered expenses** for the rest of the Calendar Year. The **prescription drug** Calendar Year **deductible** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Copays/Deductibles

| PER PRESCRIPTION COPAY/DEDUCTIBLE | NETWORK | OUT-OF-NETWORK |
|---|--------------------------------------|-------------------------------------|
| Generic Prescription Drugs | | |
| For each 30 day supply | 100% of the negotiated charge | 80% of the recognized charge |
| For more than a 30 day supply but less than a 91 day supply | 100% of the negotiated charge | Not Applicable |
| Brand-Name Prescription Drugs | | |
| For each 30 day supply | 100% of the negotiated charge | 80% of the recognized charge |
| For more than a 30 day supply but less than a 91 day supply | 100% of the negotiated charge | Not Applicable |

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

Out-of-Network Calendar Year Deductible

This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

When you incur out-of-network **covered expenses** that apply toward the out-of-network Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the out-of-network Calendar Year family **deductible** limit. Your out-of-network family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the out-of-network family **deductible** limit in a Calendar Year

Copayments and Benefit Deductible Provisions

Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

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

The **Payment/Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Payment/Maximum Out-of-Pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Payment/Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits.

This plan has an Individual **Payment/Maximum Out-of-Pocket limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual **Payment/Maximum Out-of-Pocket limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for that person.

There is also a Family **Payment/Maximum Out-of-Pocket limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets two times the individual **Payment/Maximum Out-of-Pocket Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

Expenses That Do Not Apply to Your Payment Limit

Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for outpatient treatments, including any outpatient **prescription drugs, mental disorder** treatment expenses, **substance abuse** and alcoholism treatment expenses;
- 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.

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 \$500 benefit reduction will be applied separately to each type of expense.

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.