

2024 Plans at a Glance

	Aetna EPO Plan with HRA	Aetna PPO Plan With HRA		Aetna High Deductible Plan (HDHP) With HSA ¹	
	You Pay In-network Only	You Pay In-network	You Pay Out-of-network	You Pay In-network	You Pay Out-of-network
YU HRA/HSA Account Contribution					
Base Contributions (automatic upon enrollment)					
Individual/Family	\$250/\$500	\$0 Base Contribution		\$500/\$1,000	
Additional Healthy Incentive Contribution for 2024					
Individual/Family	\$500/\$1,000	\$500/\$1,000		\$500/\$1,000	
Annual Deductible					
Individual/Family	\$1,500/\$3,750	\$1,500/\$3,750	\$4,500/\$11,250	\$2,000/\$4,000	\$4,500/\$9,000
Annual Out-of-Pocket Maximum (Includes Deductible)					
Individual/Family	\$4,000/\$8,000	\$4,000/\$10,000	\$10,500/\$25,500	\$4,000/\$8,000	\$10,500/\$21,000
Co-pays/Co-insurance					
Primary Care Physician Visits	\$25 copay/visit	\$25 copay/visit	40% after deductible	20% after deductible	40% after deductible
Specialist Office Visit	\$50 copay/visit	\$50 copay/visit		No cost to you	
Preventive Care	No cost to you	No cost to you			
Teladoc	\$25 copay/call	\$25 copay/call	N/A	\$49 copay/visit	N/A
Urgent care	\$50 copay/visit	\$50 copay/visit	40% after deductible	20% after deductible	40% after deductible
Emergency Room (copays waived if admitted)	\$250 copay/visit	\$250 copay/visit	\$250 copay/visit		20% after deductible
Inpatient Hospital	20% after deductible	20% after deductible	40% after deductible		40% after deductible
Outpatient Surgery					
Diagnostic Screenings					
Rehabilitation Therapy (physical, occupational, speech/language, vision)	\$25 copay/office visit; \$50 copay/facility visit	\$25 copay/office visit; \$50 copay/facility visit	Not covered		
Retail Prescription Drugs (up to 31-day supply)					
Tier 1 — generics	\$7.50 copay	\$7.50 copay	Covered in-network only	\$7.50 copay after deductible (deductible waived for preventive prescriptions)	Covered in-network only
Tier 2 — preferred	20% (\$60 max)	20% (\$60 max)		\$15 copay after deductible	
Tier 3 — non-preferred	40% (\$120 max)	40% (\$120 max)		20% after deductible	
Mail Order Prescription Drugs (90-day supply)					
Tier 1 — generics	\$15 copay	\$15 copay	Covered in-network only	\$15 copay after deductible	Covered in-network only
Tier 2 — preferred	20% (\$120 max)	20% (\$120 max)		\$30 copay after deductible	
Tier 3 — non-preferred	40% (\$240 max)	40% (\$240 max)		20% after deductible	
Specialty Medications					
Specialty Medications	30%	30%	Covered in-network only	20%	Covered in-network only

PrudentRX Savings Program is available to significantly reduce out-of-pocket costs for specialty medications