

2006 Aetna HMO Plan Summary
For Faculty, Administrators, Professional Research Staff, and Retirees

This chart is designed to provide an overview of this medical plan. This plan is administered by Aetna, Inc. Certain services require pre-authorization and/or a referral to be covered. For more information contact the Member Services Department of Aetna, Inc. at 1-800-323-9930 and visit Aetna's web site at www.aetna.com to locate health care providers who are part of the Aetna Standard HMO network.

BENEFIT	Your Cost
Annual Deductible – the amount you pay out-of-pocket before the plan pays benefits; does not apply to services with copays.	
• Individual	\$ 75
• Family	\$150
Your Annual Out-of-Pocket Maximum – does not apply to services with copays.	
• Individual	\$1500
• Family	\$3000
Lifetime Maximum	None
Copayment (Copay)	
• Primary Care Physician (PCP)	\$15 copay
• Specialist	\$25 copay
Coinsurance	
The percentage you pay toward the medical services you receive after you satisfy the deductible	5% of discounted fee after deductible
PREVENTIVE CARE	
Physical Examination	\$15 copay
Routine pediatric care	\$15 copay
Immunizations	\$15 copay
OUTPATIENT CARE	
Primary Care Physician office visits	\$15 copay
Specialist office visits	\$25 copay
Surgery	5% of discounted fee after deductible
Laboratory services	5% of discounted fee after deductible
Magnetic Resonance Imaging (MRI)	5% of discounted fee after deductible
ALLERGY CARE	
Initial visit, and all subsequent referral visits	\$25 copay
HOSPITAL CARE	
Physician's and surgeon's services	5% of discounted fee after deductible
Semi-private room and board	5% of discounted fee after deductible
Inpatient drugs and medication	5% of discounted fee after deductible
EMERGENCY CARE	
Ambulance service when Medically Necessary	5% of discounted fee after deductible
At hospital emergency room	\$50 copay (waived if admitted)
MATERNITY CARE	
Prenatal and post-natal care	\$15 copay at initial OB/GYN visit and 5% of discounted fee after deductible for all subsequent maternity care
Hospital Services for mother and child	5% of discounted fee after deductible
HOME HEALTH CARE	
Up to 200 home care visits per calendar year	5% of discounted fee after deductible

BENEFIT**Your Cost****SKILLED NURSING FACILITY**

Unlimited visits – Pre-certification required

5% of discounted fee after deductible

SHORT TERM REHABILITATION (Physical, Occupational, and Speech Therapies)

60 outpatient visits per calendar year

\$25 copay

SUBSTANCE ABUSE

The plan covers detoxification including medical treatment and referral services for substance abuse or addiction (inpatient rehabilitation is not covered).

5% of discounted fee after deductible

Up to 60 outpatient rehabilitation visits per calendar year

\$25 copay

MENTAL HEALTH CARE

Up to 30 outpatient visits per calendar year

\$25 copay

Up to 60 days of inpatient care per calendar year

5% of discounted fee after deductible

PRESCRIPTION DRUGS – Administered by Caremark, Inc.*Caremark Participating Retail Pharmacies (30-day supply)*

Per generic prescription

\$ 5 copay

Per brand-name prescription on Caremark's Primary Drug List

\$20 copay

Per brand-name prescription not on Caremark's Primary Drug List

\$35 copay

Caremark Mail-Service Pharmacy (90-day supply)

Per generic prescription

\$10 copay

Per brand-name prescription on Caremark's Primary Drug List

\$40 copay

Per brand-name prescription not on Caremark's Primary Drug List

\$60 copay

Note:

1. Maintenance medications must be obtained through Caremark's Mail Service Pharmacy and are limited to 2 fills per calendar year at retail. Third and subsequent fills at retail are subject to \$50 copay.
2. If you purchase a brand-name drug that is not on Caremark's Primary Drug List because there is no other brand on the market, you'll pay the Primary Drug List copay.
3. If you use an out-of-network pharmacy, you'll pay 100% of the retail price and then need to submit a claim form. You'll be reimbursed for the discounted cost of the prescription - the cost the plan would have paid had you gone to a network pharmacy - less the applicable copay. In most cases, the discounted price will be less than the retail price.

HOSPICE CARE

Limited to 210 days lifetime maximum

5% of discounted fee after deductible

ALTERNATIVE MEDICINE

Chiropractic visits (38 visit limit per calendar year)

\$25 copay

Acupuncture

\$25 copay per office visit, 5% of discounted fee after deductible when performed as anesthesia in a facility

OTHER SERVICES

Durable Medical Equipment (Must be approved in advance)

5% of discounted fee after deductible

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The benefit plan description only highlights these benefits. More complete information and important exclusions can be found in the Summary Plan Description (SPD) which is available online on the Benefits Resource Center via NYUHome (www.home.nyu.edu-click on Work tab) or from the NYU Benefits Office: email benefits@nyu.edu or call 212-998-1270. The formal plan documents, available in the NYU Benefits Office, contain all the plan details and legally govern the plan's operation. The University reserves the right to change, amend or terminate benefit plans at any time.

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