

Aetna HMO

Summary Plan Description

Participants

NYU Retirees

Not Medicare-Eligible

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Table of Contents:

Introduction	3
Eligibility.....	3
Enrollment	5
Cost	6
How the plan works	8
Covered expenses	9
Restrictions and exclusions	17
Coordination of benefits.....	20
When coverage ends.....	26
Administrative information	28
Contacts	32
Definitions	34

Introduction

The University gives you the option to choose a medical plan that works best for you and your eligible dependents. You can choose either a Point-of-Service plan, an indemnity plan, or a health maintenance organization (HMO) one or more may be available in your area.

Under the Aetna HMO you select a primary care physician (PCP) who will manage your care and refer you to a specialist in the network. Except in an emergency, you do not receive benefits if you receive care outside of the network.

You will need to satisfy the requirements described in this summary plan description (SPD) to receive Aetna HMO coverage.

This SPD provides a concise overview of medical coverage available for you and your eligible dependents. While this SPD contains detailed and important information about your benefit plan, every attempt has been made to communicate that information clearly and in easily understandable terms.

Benefits are determined under the terms of the plan in effect at the time you become eligible for the benefits in question. The University reserves the right to suspend, modify, or terminate these benefits at any time to the extent permitted by law. This SPD does not constitute a contract of employment or guarantee any particular benefit.

In the event of a discrepancy between this SPD and the plan document, the plan document will govern.

Eligibility

Eligible retirees

You are eligible for Aetna HMO coverage if you are:

Not Medicare-Eligible and you retire from NYU on or after January 1, 1989, were eligible to participate in one of the University's group health plans immediately before retirement, and are a member of one of the following six groups of employees:

- Faculty (code 102)
- Professional Research staff (code 103)
- Administrative and Professional staff (code 100)
- Office and Clerical staff (code 106)
- Laboratory and Technical staff (code 104)
- Sergeant Guards (Code 107 PRG SGT)
- Service and Maintenance staff (code 107 who are in Local 810, Local 1 Security Officers Union, and non-union Service and Maintenance staff).

Eligible dependents

You can cover certain dependents under Aetna HMO coverage. You're required to provide proof of relationship of your dependents if you elect to cover them under the plan. This may include a copy of one of the following: marriage certificate, approved NYU Statement of Domestic Partnership form, birth certificate that shows the names of both the parent and the child, final adoption papers, legal documentation substantiating placement for adoption, a court order (from a court of competent jurisdiction) showing legal guardianship, permanent or temporary custody.

Your eligible dependents are any of the following

- your legal spouse
- your domestic partner whom you registered with the NYU Benefits Office
- your unmarried, dependent child under age 19
- your unmarried, dependent child over age 19, up to age 25, if a full-time student at an accredited educational institution
- your unmarried, dependent child over age 19 if mentally or physically disabled

Your dependent children include:

- your natural child
- your stepchild
- your registered domestic partner's child
- your legally adopted child (or child placed with you for legal adoption)
- a child for whom you have been appointed legal guardian by a court of competent jurisdiction
- a child for whom you have been given temporary or permanent custody under an order issued by a court of competent jurisdiction

A newborn child is eligible for coverage at birth. In the case of an adoption, a child becomes eligible for coverage when

- the child is placed in your home or
- the adoption is final
- In order to obtain coverage for your new child, you must enroll the child within 31 days of its birth, the date the child is placed in your home for adoption, the date the adoption is final, the date that you have been appointed legal guardian or the date you were awarded permanent or temporary custody.

In the case of temporary custody, you will be required to submit either another order which extends the period of temporary custody or an order of permanent custody in order for the child's coverage to remain

in effect.

If both you and your spouse or registered domestic partner work for NYU and are eligible for a medical plan through NYU, only you or your spouse can cover your child as a dependent under one plan. Both of you cannot cover your child at the same time. Also, your child has to meet the eligibility requirements.

If both you and your spouse work for NYU, you can cover your spouse or partner as a dependent under your plan, or your spouse or partner can elect separate employee coverage. You or your spouse or partner cannot be covered as both an employee and as a dependent under the plan.

Qualified Medical Child Support Order (QMCSO)

You or your dependents can obtain a description of procedures for Qualified Medical Support Order determinations at no charge from the NYU Benefits Office.

Enrollment

Enrolling in the plan

You have 31 days from your retirement date to enroll in Aetna HMO coverage, unless you elect to waive coverage on your enrollment form. If you do not complete an enrollment form, you will not be covered under any plan.

When coverage begins

Once enrolled, you and your eligible dependents' Aetna HMO coverage will become effective on the first day of the month after your retirement.

If you have a qualifying status change and become eligible for coverage during the plan year, your Aetna HMO coverage will start on the date of the event.

Making changes

You may change Aetna HMO coverage during the year if you have a qualifying status change; otherwise, you may only make changes during open enrollment.

Changes in election

If you have a qualifying status change, you can change your existing NYU medical plan or enroll in coverage for the first time if you previously waived coverage. A change in election due to a qualifying status change must be consistent with the qualifying status change. You must make changes to your coverage within 31 days of your qualifying status change. The following is a list of events that are considered to be a qualifying status change:

- your marital status changes (or you register or revoke a domestic partnership)
- you increase or decrease your number of dependents (birth, death, adoption or placement for adoption, guardianship, permanent or temporary custody)
- your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age 19 or 25 if a full-time student or marries)
- a court decree that orders you must provide health coverage for your dependent
- your dependent's Medicare/Medicaid eligibility status changes

- your spouse's/partner's employer's plan has a different plan year and open enrollment period than NYU's
- coverage under your spouse's/partner's plan is significantly curtailed or ceases
- your spouse's/partner's employer adds new health plan options
- NYU adds new health plan options
- you or your spouse/partner commence or return from an FMLA leave
- you increase or decrease your number of dependents (birth, death, adoption or placement for adoption, guardianship, permanent or temporary custody)
- you or your dependent's residence changes
- you or your dependent's work site changes
- your spouse's/partner's employer adds new health plan options
- you or your spouse/partner commence or return from an FMLA leave

Changes you make within 31 days of a qualifying status change become effective on the date of the event.

Changes during open enrollment

You may change your Aetna HMO coverage once a year during open enrollment, except as provided in the **Changes in election** section.

During the open enrollment period, you may do any of the following:

-
- drop your coverage
 - elect coverage if previously waived
 - change your coverage level

All changes in Aetna HMO coverage made during open enrollment will become effective on the first day of the new **plan year**.

Special enrollment rules

If you are waiving NYU medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, guardianship, permanent or temporary custody, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption, guardianship, permanent or temporary custody.

Cost

You and NYU share the cost of your healthcare. Your cost includes any premiums, deductible, copays, and coinsurance amounts that may be required by the plan. You should consider these factors when deciding which plan is best for you. An online tool is available on the NYU Benefits Resource Center to help you estimate your costs. Click on Health Plan Costs and FSA Estimator when you visit the Benefits Resource Center web site.

Monthly contributions

You and NYU share the cost of coverage.

Deductible

The deductible is the amount of money you must pay each plan year for covered medical care before the plan begins to pay benefits. You must satisfy an annual deductible. The plan has both individual and family deductibles.

Individual deductible

The individual deductible applies to each covered person. Once you meet the individual deductible, the plan begins paying benefits. The individual deductible is \$100.

Family deductible

To meet the family deductible, one family member must meet the individual deductible and the expenses of other family members can be combined to meet the balance of the family deductible. The family deductible is \$200.

Copay

The copay is the flat dollar amount you pay for certain expenses. The plan has a lower copay for services received from a primary care physician and a higher copay for services rendered by a specialist. Once you pay your copay for a service, the plan pays 100% of the remainder. The copay does not get credited toward meeting your annual deductible or out-of-pocket limit.

The co-pays under the Aetna HMO coverage apply to:

- office visits
- PCP/specialist visits
- routine physical exams
- well child care and immunizations
- annual OB/GYN exams
- routine eye exams
- routine hearing exams
- emergency room (waived if admitted)
- allergy testing and treatment
- outpatient short-term physical/occupational/speech therapies
- chiropractic care
- outpatient mental health care
- outpatient chemical dependency (substance abuse) care

Coinsurance

Coinsurance is the percentage of expenses that you are responsible for paying after you meet the deductible. Aetna HMO coverage pays 95% of covered expenses (unless a copay applies) after you have satisfied the annual deductible. Once you reach the annual out-of-pocket limit, the plan pays 100% of covered expenses for the remainder of the calendar year.

Annual out-of-pocket limit

The annual out-of-pocket limit is the maximum amount you pay for your share of covered expenses each year. Once you reach the individual or family out-of-pocket limit, the plan pays 100% of covered expenses for the rest of the calendar year.

Expenses that count toward your annual out-of-pocket limit include:

- coinsurance
- deductibles

These expenses do not apply to the out-of-pocket limit:

- charges that exceed individual benefit maximums
- charges where co-pays apply
- prescription drug benefits

Individual out-of-pocket limit

The individual out-of-pocket limit applies to each covered person. The out-of-pocket limit is \$2,000 per year.

Family out-of-pocket limit

To meet the family out-of-pocket limit, one family member must satisfy the individual out-of-pocket limit, and the expenses of other family members can be combined to satisfy the balance of the family out-of-pocket limit. The family out-of-pocket limit is \$4,000.

Annual benefit maximums and visit limits

The Aetna HMO plan covers a maximum number of visits per calendar year or per lifetime for the following services:

- chiropractic care - 38 visits per calendar year
- home health care - 200 visits per calendar year
- hospice care - 210 days per lifetime
- inpatient mental health - 60 days per calendar year
- outpatient mental health - 30 visits per calendar year
- outpatient substance abuse - 60 visits per calendar year
- short-term rehabilitation (physical, occupational, and speech therapies) - 60 outpatient visits per calendar year

Once you receive benefits for the maximum number of visits allowed by the plan in a calendar year, you pay 100% of the cost of any remaining visits in the calendar year. Visits beyond the calendar year maximum do not go against the plan's deductible or out-of-pocket maximum. You receive a new allowance of visits for each new calendar year.

Lifetime maximum benefit

The lifetime maximum benefit is the limit the plan will pay in each covered person's lifetime. The plan has no lifetime maximum benefit.

How the plan works

When you enroll in the Aetna HMO plan you and your covered dependents must select a Primary Care Physician (PCP) who is part of the Aetna Standard HMO network. In general, to receive care from a specialist or other provider who is part of the Aetna network you must first obtain a referral from your PCP.

Referrals

You must have a prior written or electronic referral from your PCP to obtain services and any necessary follow-up treatment from a specialist or facility.

If it is necessary, your PCP may refer you to a non-network provider for covered services that are not available within the network. Service from non-network providers require prior approval by Aetna in addition to a special non-network referral from your PCP.

You do not need a referral to obtain care from your PCP for services for routine vision care, and for gynecological exams.

The specialist as principal physician direct access program

Aetna also has a program called the Specialist as Principal Physician Direct Access Program where the specialist acts a principal physician. If you have a serious or complex medical condition, you may need ongoing specialty care.

The Specialist as Principal Physician Direct Access Program is a voluntary program. Eligibility is based upon the nature of your medical condition, your need for continuing specialty care, and a specialist's willingness to serve as your principal physician for treatment of the condition. Enrollment in the program must be approved by Aetna. Once you are enrolled, a case manager will be available to answer questions about the features of the program, to assist with any necessary authorization or pre-certifications, and to facilitate communications between your PCP and the specialist treating your condition. You should contact Aetna's Member Services at the toll free number shown on your ID card and ask to be transferred to a disease management representative to enroll.

Network of doctors and hospitals

Aetna HMO's network includes general practitioners, as well as specialists and hospitals. These network providers are selected by Aetna. You get benefits only when you are treated by providers in the network. You can access a listing of these network providers at www.aetna.com and searching the directory for the Aetna Standard HMO network. You will need to enter your user ID and password. Or call Aetna's Member Services at 800-323-9930.

Primary care physician

A primary care physician (PCP) is a doctor in the Aetna Standard HMO network who you choose to manage all of your health care. Your primary care physician provides preventive and routine care like office visits, diagnoses, and treats minor, uncomplicated illnesses and injuries. Your PCP refers you to Aetna's network of specialists and hospitals, as needed. A PCP can be an internist, a family or general practitioner, or a pediatrician for children. You choose your PCP from the network of doctors.

Selecting or changing primary care physicians

Each member of your family must choose a primary care physician. You select a physician from the Aetna provider directory. You can locate the provider directory on Aetna's website at www.aetna.com or by calling Aetna at 800-323-9930.

You can change your primary care physician at any time.

Network of mental health and substance abuse providers

For mental health or substance abuse treatment contact Member Services at the telephone number shown on your ID card before treatment. Member Services will connect you with the behavioral health

vendor, and you can speak with a clinical care manager who will assess your situation and refer you to participating providers, as needed.

Network of retail and mail-order pharmacies

Prescription drug coverage under the plan includes a retail prescription drug program and a mail order prescription drug service, both of which are administered by Caremark, Inc. Log on to www.caremark.com or call 800-421-5501 to locate a Caremark retail pharmacy or obtain forms for Caremark's Mail Service pharmacy. Forms are also available online on the NYU Benefits Resource Center and www.nyu.edu/hr.

When to seek pre-certification

Network providers are responsible for obtaining any pre-certifications that are required by Aetna.

Durable Medical Equipment

Purchase or rental of durable medical equipment must be approved by Aetna in advance.

Maternity

Pre-certification is required for the following maternity services:

- Inpatient stay of a mother and/or the newborn that will be more than:
- 48 hours for the mother and newborn child following a normal vaginal delivery or
- 96 hours for the mother and newborn child following a cesarean section delivery

Your participating obstetrician is responsible for obtaining authorization from Aetna for all obstetrical care after your first visit. They must request pre-certification for any tests performed outside of his or her office and for visits to other specialists. It is up to you to verify that the necessary referral has been obtained before receiving such services.

Mental Health and Substance Abuse Treatment

You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you seek treatment for mental health or substance abuse, you need to call Member Services at the telephone number shown on your ID card. Member services will connect you with the behavioral health vendor, and you can speak with a clinical care manager who will assess your situation and refer you to participating providers, as needed. All calls are confidential.

Organ Transplants

Your participating physician is responsible for obtaining authorization from Aetna. It is up to you to verify that the necessary referral has been obtained before receiving such services.

Coverage when you are away from home or your child is away at school

When you travel outside of the Aetna service area or if your child is away at school, Aetna covers emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Your PCP should be called as soon as possible after receiving treatment.

If the provider of emergency services does not submit the claim to Aetna for you and bills you instead, you will need to submit the claim to Aetna. You can obtain a claim form by visiting Aetna's web site at www.aetna.com, Forms Library or contact Aetna Member Services. Send the completed claim form and itemized bill for payment with your ID number clearly marked to the address shown on your ID card.

Covered expenses

In order for a specific service to be covered under the plan it must be medically necessary for the prevention, diagnosis or treatment of your illness or condition. In general, to receive care from a specialist or other provider who is part of the Aetna network you must first obtain a referral from your PCP. See How the Plan Works.

Preventive Care

Physical exams for adults

Annual routine physical exams for adults are covered by the plan.

Physical exams for children

Annual routine physical exams for children are covered by the plan.

Pap smears

Annual routine Pap smears are covered by the plan. If your doctor recommends a non-routine Pap smear as a follow-up to a medical diagnosis, the plan covers your Pap smear the same as any other laboratory charge.

Mammograms

Annual routine mammograms are covered.

Prostate specific antigen test - PSA

Annual routine prostate specific antigen (PSA) tests are covered by the plan. If your doctor recommends a non-routine PSA test as a follow-up to a medical diagnosis, the plan covers your PSA test the same as any other laboratory expense.

Routine eye exams

Routine eye exams are covered when performed by your PCP or a network ophthalmologist as part your annual routine physical exam.

Routine hearing exams

Routine hearing exams are covered when performed by your PCP as part your annual routine physical exam.

Specialist care

Offices visits to specialists are covered. A referral from a Primary Care Physician (PCP) is required to seek treatment from a specialist.

Maternity care

Prenatal visits

The plan covers prenatal visits.

Doctor's delivery charge

The plan covers charges for delivery of the baby.

Midwives

The plan covers the services of midwives.

Maternity hospital stay

Hospital stays for maternity are covered for prenatal care; delivery of a child or children; postpartum care rendered within 24 hours after the delivery; services of an operating physician for performing an obstetrical procedure, related pre-operative and post-operative care, administration of an anesthetic; and services of any other physician for administering a general anesthetic.

Birthing centers

Birthing center expenses are covered for prenatal care; delivery of a child or children; postpartum care rendered within 24 hours after the delivery; services of an operating physician for performing an obstetrical procedure, related pre-operative and post-operative care, administration of an anesthetic; and services of any other physician for administering a general anesthetic.

Baby's first exam

Baby's first exam is covered during a newborn child's initial hospital confinement. Covered expenses

include hospital services for nursery care; other services and supplies given by the hospital; services of a surgeon for circumcision; and physician services.

Mental health and substance abuse treatment (in- and outpatient)

Inpatient treatment

is covered for mental health conditions in a hospital or mental health facility. The plan covers expenses for substance abuse treatment in a hospital for detoxification, including medical treatment and referral services for substance abuse or addiction. Inpatient rehabilitation for substance abuse is not covered.

Outpatient treatment

is covered for treatment of mental health conditions. The plan covers outpatient rehabilitation visits for treatment of substance abuse.

Emergency care

An emergency is defined as a serious medical condition or symptom (including severe pain) which results from an injury, sickness, or mental illness. Generally, the condition arises suddenly and requires immediate care and treatment usually within 24 hours of onset to avoid jeopardy of a covered person's life or health. If you are admitted to the hospital, you need to contact Member Services within 24 hours of admittance.

Examples of conditions that would typically be considered emergencies are chest pain, severe bleeding, appendicitis, poisoning, seizures, strokes and loss of consciousness.

Hospital emergency room

Emergency care (see above) in a hospital emergency room is covered by the plan. Coverage is the same for both in-and out-of-network care. You pay an emergency room copay which will be waived if you are admitted to stay overnight. Call Member Services within 24 hours of your admission to the hospital.

Ambulance

Ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given is covered by the plan. Or, a professional ambulance service, when used to transport you to or from a local hospital when ordered by a physician, surgeon, paramedic, or an officer of the law, is covered by the plan.

Inpatient care

Inpatient hospital services

Generally, covered hospital expenses include charges for semi-private room and board and other medically necessary services and supplies. Room and board charges include all hospital charges for services, such as general nursing care, made in connection with room occupancy as well as:

- anesthetics and oxygen,
- blood transfusion equipment and administration of blood or blood derivatives by a hospital employee,
- diagnostic lab work and x-rays,
- dressings and plaster casts,
- drugs and medicines,
- hem dialysis or peritoneal dialysis for kidney failure,
- in-hospital consultation with attending physician,
- nurses and physicians services,
- sera, biological, vaccines, and intravenous preparations,
- splints, trusses, braces, and crutches,
- surgical supplies,
- x-ray, radium, and radioactive isotope therapy, and chemotherapy treatment and associated administration equipment and supplies.

Not included is any charge for daily room and board in a private room over the semi-private room charge.

Surgery

The services of surgeons, assistant surgeons and anesthesiologists are covered.

Multiple surgical procedures

Multiple surgical procedures are covered by the plan. When more than one surgical procedure is performed in the same operative session a special coverage rule applies. The expense for each surgical procedure is considered individually and after the applicable deductible is applied the plan will cover 100% of the reasonable and customary (R&C) charge for the primary procedure, 50% of the R&C charge for the secondary procedure, and 25% of the R&C charge for the tertiary and any additional procedures.

Second surgical opinion

Second surgical opinions are not required by the plan to obtain benefits. The plan covers second surgical opinions, provided you first get a referral from your PCP.

Reconstructive surgery

The plan covers reconstructive surgery when the purpose is to improve the function of a part of the body that is malformed as a result of a severe birth defect, including harelip, webbed fingers or toes, or a malformation as a direct result of disease or surgery.

Hospice

Inpatient and outpatient hospice care expenses are covered when provided as part of a hospice care program. Covered services include:

- Inpatient treatment in a hospice facility, hospital, or convalescent facility that provides room and board and other services and supplies for pain control, as well as other acute and chronic symptom management;
- Bereavement counseling for family members by a licensed clinical social worker (or a licensed pastoral counselor, except when administered to a member of his or her congregation).

Charges made by a hospice care agency for: part-time or intermittent nursing care by a registered nurse or licensed practical nurse, for up to eight hours in any one day; medical social services under the direction of a physician; psychological and dietary counseling; consultation or case management services by a physician; physical and occupational therapy; part-time or intermittent home health care aide services for up to eight hours in any one day, consisting mainly of caring for the person; and medical supplies, drugs, and medicines prescribed by a physician.

Physical therapy/rehabilitation

Inpatient physical therapy/rehabilitation is covered provided there is a specific treatment plan that details the nature and duration of the physical therapy and allows for ongoing review to determine the need for further physical therapy treatment. The therapist must submit progress reports at the intervals stated in the treatment plan to Aetna.

Skilled nursing facility

The plan covers services received in a convalescent facility.

Outpatient care

Outpatient hospital and alternate facility services

Outpatient hospital and alternate facility services are covered. Generally outpatient hospital and alternate facility expenses include charges for services, such as general nursing care and for medically necessary services and supplies.

Surgery

The services of surgeons, assistant surgeons and anesthesiologists are covered.

Multiple surgical procedures

Multiple surgical procedures are covered by the plan. When more than one surgical procedure is performed in the same operative session a special coverage rule applies. The expense for each surgical procedure is considered individually and after the applicable deductible is applied the plan will cover 100% of the reasonable and customary (R&C) charge for the primary procedure, 50% of the R&C charge for the secondary procedure, and 25% of the R&C charge for the tertiary and any additional procedures.

Second surgical opinion

Second surgical opinions are not required by the plan to obtain benefits. The plan covers second surgical opinions.

Home health care

Home health care is covered if provided through a home health care agency if a covered person is confined to his or her home and requires nursing care, therapy, or other services. The covered person's physician must prescribe a home health care plan, and the treatment received must be an alternative to care in a hospital or convalescent facility. Each visit by a nurse or therapist, or by a home health aide of up to four hours, is considered one visit. Covered home health care expenses include:

- Care by a registered nurse, licensed practical nurse, home health aide, nurse's aide, licensed clinical social worker, or therapist employed by a home health care agency;
- Home health aide services for patient care;
- Medical social services.

Specialty care

Acupuncture

Acupuncture treatment is covered when received from a licensed medical doctor. Outpatient acupuncture treatment must be medically necessary and preauthorized by Aetna. Also, see Special Aetna Programs.

Alternative care (see acupuncture and chiropractic care)

See Special Aetna Programs.

Allergy testing and treatment

Allergy testing and treatment are covered by the plan.

Chemotherapy/radiation therapy

Chemotherapy and radiation therapy are covered by the plan.

Chiropractic care

Treatment for misalignment or dislocation of the spine and strained muscles or ligaments related to the spinal disorder is covered by the plan.

Dental treatment

Generally, dental care is not covered under a medical plan. However, this plan covers oral surgery which is limited to extraction of bony, impacted teeth; treatment of bone fractures; removal of tumors and orthodontogenic cysts.

Dialysis

Dialysis is covered to treat acute or chronic kidney disease, including outpatient dialysis in your home, a hospital outpatient department or a free-standing facility. Coverage includes: lab tests related to the dialysis program; appropriate and necessary supplies if bought and billed through a hospital; rental of required equipment; and training of your family or other persons who assist in the use of the required equipment.

Durable medical equipment

Durable medical equipment is covered by the plan. Supplies include wheelchairs; crutches; hospital-type beds; equipment to provide oxygen; iron lung; other mechanical equipment to treat respiratory paralysis; orthotic devices such as arm, neck, and back braces; appliances which replace a lost body organ or part or help an impaired one to work; and monitoring devices.

Immunizations

The plan covers immunizations or vaccinations for your child.

Infertility treatment

Coverage for infertility treatment is limited to the diagnosis and treatment of the underlying condition and includes surgery and drug therapy. Drug therapy is covered through Caremark (see Prescription Drugs).

Occupational therapy/rehabilitation (outpatient short-term)

Occupational therapy is covered by the plan except for vocational rehabilitation and employment counseling.

Organ transplants

Organ transplants are covered by the plan.

The plan covers medically necessary hospital services for kidney, corneal, heart, heart/lung, lung, pancreas, bone marrow, liver, and multiple major organ transplant procedures as long as pre-certification is obtained and the transplant is performed in an approved facility.

Contact Aetna for details on coverage, storage, transportation costs and travel expenses.

Physical therapy/rehabilitation (outpatient short-term)

Physical therapy is covered by the plan provided there is a specific treatment plan that details the nature and duration of the physical therapy and allows for ongoing review to determine the need for further physical therapy treatment. The therapist must submit progress reports at the intervals stated in the treatment plan.

Prostheses

Prostheses after a mastectomy, artificial limbs and eyes (purchase, fitting, needed adjustments, repairs, and replacements) and other prosthetic appliances are covered by the plan when approved by the claims administrator.

Speech therapy (outpatient short-term)

Speech therapy is covered by the plan provided it is given by a licensed speech therapist to restore speech lost or impaired due to surgery, radiation therapy, or other treatment which affects the vocal chords; cerebral thrombosis (cerebral vascular accident); brain damage due to accidental injury or organic brain lesion (aphasia).

Speech therapy is covered by the plan for children under age three whose speech is impaired due to infantile autism; developmental delay or cerebral palsy; hearing impairment; or major congenital anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.

Sterilization and reversal of sterilization

Tubal ligation and vasectomy are covered by the plan.

X-ray, laboratory, and diagnostic services

The plan covers diagnostic laboratory test and x-rays, including CAT scans, and Magnetic Resonance Imaging (MRIs).

Prescription drugs

Prescription drug coverage under the plan includes a retail prescription drug program and a mail service prescription drug service, both of which are administered by Caremark. Your prescription benefit is the same, regardless of whether your prescription is issued by an in- or out-of-network physician.

Co-pays that you pay for prescription drug expenses are not subject to the plan's deductible and are not counted toward your annual out-of-pocket maximum.

Your copayment will depend on the type of drug you obtain:

- generic,
- brand-name medication on Caremark's Primary Drug List, or
- brand-name medication not on Caremark's Primary Drug List.

Your copayment will be lowest when you choose a generic drug. If you obtain a brand-name medication from Caremark's Primary Drug List, your copayment will be lower than if you choose a brand-name medication that is not on the Primary Drug List. If you purchase a brand-name medication that is not on Caremark's Primary Drug List because there is no other brand on the market, you will pay the Primary Drug List copayment, which is lower.

If the cost for your generic or brand-name prescription drug is less than the copay, you pay the lower dollar amount. For example, if the cost of a generic prescription drug is \$3, you pay the \$3 cost for the medication - not the \$5 copay for generic prescription drugs, as specified under the plan.

Caremark mail-service pharmacy

Maintenance drugs are drugs that are prescribed for certain ongoing or chronic conditions (like high blood pressure or hypothyroidism) and are generally taken for long periods of time. Use the Caremark Mail Service pharmacy for medications that you need for long-term use, usually a supply of 90-days or more, or for short term use if they are on Caremark's maintenance drug list.

Caremark retail pharmacy

Use a Caremark retail pharmacy for medications that you will take for the short-term, usually a supply of 30-days or less. The number of times you can fill a maintenance mail-service prescription at a retail pharmacy is limited to two 'fills' per calendar year. The third and each subsequent fill of your maintenance medication at a retail pharmacy is subject to a \$50 copayment.

Non-Caremark pharmacy

In the event you do go to a non-participating pharmacy, you will pay the full retail price for the prescription. You will then need to submit a paper claim form, along with the original prescription receipt(s) to Caremark for reimbursement. You will be reimbursed for the discounted cost of the prescription - the cost the plan would have paid if the prescription had been filled at a Caremark participating pharmacy - less the applicable copayment. In most cases, the discounted price will be less than the retail price, so you may end up paying more when you use a non-participating pharmacy.

Special Aetna programs

The following programs are some, but not all, of the special programs offered by Aetna. These programs are not part of the NYU medical plan design as outlined in NYU's legal Plan Document. The continuation

of these programs is not guaranteed and Aetna reserves the right to amend or discontinue any or all of these programs. For more information about these programs contact Aetna Member Services or log onto www.aetna.com.

Alternative Health Care Programs

- You can get special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists, and nutritional counselors.
- Natural Products Program: You can save on many health-related products, including aromatherapy, foot care and natural body care products.
- Vitamin Advantage Program: Save on over-the counter vitamins and nutritional supplements purchased through participating vendors.

Programs for Women

- Direct Access for OB/GYN Care: Women have direct access to participating obstetrical, gynecological or women's principal health care professionals for routine maternity care, an annual well-woman exam as well as unlimited number of visits for gynecological-related problems. No referrals required.
- Moms-to-Babies Maternity Management Program: You can receive educational materials on prenatal care, labor and delivery, newborn and baby care, postpartum depression, breastfeeding, as well as special information for your partner. The program also offers: a pregnancy risk survey, access to breastfeeding support, nurse care coordination for high-risk pregnancy and nicotine-free pregnancy smoking-cessation program.
- Preventive screening reminders for breast and cervical cancer.
- Women's Health Online
- The Infertility Program

EyeMed Vision Care Discount Program

- You are eligible to receive discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the EyeMed Plan at thousands of locations nationwide. Just call 866-559-5252 for information and the location nearest you.
- You are also eligible to receive a discount off the provider's usual retail charge for Lasik surgery (the laser vision corrective procedure). Included in the discounted price is patient education, an initial screening, the Lasik procedure and follow-up care.

Wellness and Prevention Programs

- Member Health Education Reminders: You can receive preventive health care reminders to encourage the use of available services to prevent, detect and monitor problems early on.
- Healthy Outlook Program for people with chronic conditions such as asthma, diabetes, chronic heart failure or coronary artery disease.
- National Medical Excellence Program: The programs will support, guide and help you access appropriate care if you or your family is ever faced with a transplant or complex medical procedure, or requires access to medical care when traveling abroad.
- National Transplantation Program: Provides access to a registered nurse transplant manager who helps during every phase of the transplant process, coordinates care and helps you access

facilities that have exhibited successful clinical outcomes, offers travel and lodging allowance (if preauthorized by Aetna).

- National Special Case Program: Collaborates with you and your health care team in evaluating your treatment options for rare or complex conditions.
- Out-of-Country Care Program: Provides support in accessing medical care if you are admitted to the hospital for a medical emergency while traveling abroad.

Restrictions and exclusions

Pre-existing condition limitation

There are no exclusions or limitations for pre-existing conditions under this plan.

Expenses not covered

General exclusions

Generally, coverage under the plan is only provided for a service or supply which is necessary for the diagnosis, care or treatment of the physical or mental condition involved. It must be widely accepted professionally in the United States as effective, appropriate, and essential based on the recognized standards of the health care specialty involved. Specifically, coverage is not provided for the following:

- Any service in connection with, or required by, a procedure or benefit not covered by the plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by Aetna.
- Blood, blood plasma or other blood derivatives or substitutes.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Educational services, special education, remedial education or job training. The plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunctions, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

This exclusion will not apply to drugs that have been granted treatment investigational new drug (IND) or Group c/treatment IND status or that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, take-home supplies, and other similar items and services.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Services not covered by the plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state or federal government, securing insurance coverage, travel, and school admissions or attendance, including examinations required to participate in athletics unless the services is considered to be part of an appropriate schedule of wellness services.
- services and supplies that are not medically necessary.
- services you are not legally obligated to pay for in the absence of this coverage.
- special medical reports, including those not directly related to the medical treatment of a plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- thermo grams and thermographs
- treatment in a federal, state or governmental facility, including care and treatment provided in a non-participating hospital owned or operated by any federal, state or governmental entity, except to the extent required by applicable laws.
- treatment of diseases, injuries, or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- treatment of injuries sustained while committing a felony.
- treatment of sickness or injury covered by a worker's compensation act or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.

Preventive care exclusions

- Hearing aids
- Immunizations related to travel or work
- Orthotics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision)
- Routine hand and foot care services, including routine reduction of nails, calluses and corns
- Weight reduction programs and dietary supplements

Mental health and substance abuse treatment exclusions

- Hypnotherapy, except when approved in advance by Aetna
- Religious, marital and sex counseling, including related services and treatment.
- Therapy or rehabilitation, including (but not limited to) primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide therapy.
- Treatment, including therapy, supplies, and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to medical treatment of retarded individuals as described under "How the plan works."

Inpatient care exclusions

- Ambulance services, when used as routine transportation to receive inpatient and outpatient services.
- Custodial care and rest cures.
- Private duty or special nursing care.

Surgery

- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the plan covers the following reconstructive surgery to correct the results of an injury, surgery to treat congenital defects (such as a cleft lip and cleft plate) to restore normal bodily function, and surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Reversal of voluntary sterilizations, including related follow-up care
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Transsexual surgery, sex change or transformation. The plan does not cover any procedure, treatment or related service designed to alter a plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

Outpatient care exclusions

- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips.
- Private duty or special nursing care

Specialty care exclusions

Allergy treatment

- Specific non-standard allergy services and supplies, including (but not limited to):
 - skin titration (wrinkle method),
 - cytotoxicity testing (Bryan's Test),
 - treatment of non-specific candida sensitivity, and
 - urine auto injections.

Dental treatment

Dental care and treatment, including (but not limited to):

- care, filling, removal or replacement of teeth,
- dental services related to the gums,
- apicoectomy (dental root resection),
- orthodontics,
- root canal treatment,
- soft tissue impactions,
- alveolectomy,
- augmentation and vestibuloplasty treatment of periodontal disease,
- prosthetic restoration of dental implants, and
- dental implants.
- False teeth.

Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):

- treatment performed by prosthesis placed directly on the teeth,
- surgical and non-surgical medical and dental services, and
- diagnostic or therapeutic services related to TMJ

Durable medical equipment

- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Orthotics.

Speech therapy

- Special education, including lessons in sign language to instruct a plan participant whose ability to speak has been lost or impaired to function without that ability.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects

Infertility treatment

- Infertility services, except as described under "Covered Expenses." The plan does not cover injectible infertility drugs; charges for freezing and storage of cry preserved embryos; charges for storage of sperm; and donor costs, including (but not limited to) the cost of donor eggs and donor sperm, the costs for ovulation predictor kits, and the costs for donor egg programs or gestational carriers.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, the plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the services or treatment in advance.

Coordination of benefits

If you or a covered dependent is covered by another medical plan, Aetna HMO coverage has a coordination of benefits feature to prevent duplication of benefit payments.

Coordination of benefits allows the plans to work together to cover eligible expenses. The plan that has the first obligation to pay is called the "primary plan;" the other plan is called the "secondary plan." Typically, a secondary plan will pay when its benefit is more generous.

A participant may be covered as a dependent under two or more plans. Certain rules govern which plan is primary and which is secondary. Those rules follow this order:

- A plan that has no coordination of benefits provision will be primary to a plan that does have a coordination of benefits provision.
- The plan of the participant whose birthday falls earlier in the calendar year is primary before the plan of the participant whose birthday falls later that year (based on month and day only).
- If both participants have the same birthday, the plan covering the person for the longest time is considered primary before the plan that covers the other person.
- If the other benefit plan doesn't have the rules described above, but instead has a rule based on the participant's gender, and if as a result the plans don't agree on the order of the benefits, the rule in the other benefit plan will determine the order of the benefits.

A participant may be covered as a dependent under two or more plans of divorced or separated parents. The following rules determine which plan is primary and which is secondary:

- If the other benefit plan doesn't have the rules described above, but instead has a rule based on the participant's gender, and if as a result the plans don't agree on the order of benefits, the rule in the other benefit plan will determine the order of benefits.
- If the parent with custody has remarried, the order of payment is the plan of the parent with custody will pay first, followed by the plan of the stepparent with custody, and followed by the plan of the parent without custody.
- If there is a court decree giving one parent financial responsibility for the medical, dental or other health expenses of the dependent child, this parent's plan will be primary to any other plan that covers the dependent child.
- If none of these rules apply, the plan that has covered the person for the longest time will be primary to all other plans.

Under coordination of benefits, if the NYU plan is the secondary payer, the NYU plan will pay the difference between the total covered charges and the amount the primary plan paid. The total payments of both plans can't be more than 100% of the covered expenses. The benefits paid by the NYU plan can't be more than the amount the plan would have paid if there was no other coverage, but together with the primary plan, most - if not all - of the covered expense may be paid.

How to file a claim

Two advantages of being a participant in the plan are that you submit no claim forms and you should not receive any bills. However, if you should receive a bill for covered services, please send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card. You can obtain a claim form by visiting Aetna's web site at www.aetna.com, Forms library, or contact Member Services to request a form.

In the following circumstances, the plan will not pay your bill:

- You receive treatment from a doctor or facility in a non-emergency situation without a prior referral from your PCP, or without appropriate authorization from Aetna when required.
- You receive medical treatment that has not been authorized on your referral (i.e., X-rays or lab work).
- You go directly to an emergency center for treatment in your service area when it is not an emergency.
- You receive post-emergency follow-up treatment from a nonparticipating provider without appropriate authorization.
- You receive services that are not covered by the plan.
- You receive non-emergency services from a nonparticipating provider without a prior referral from your PCP and the prior approval of Aetna.
- This plan is not the primary plan.

If a claim is denied

Aetna has a grievance resolution process designed to promptly address member problems. If you have a problem, call the Member Services toll-free number on your ID card or write to Member Services at the address on your ID card.

Or, e-mail Member Services at www.aetna.com. Please be sure to include your member ID number, Social Security number and e-mail address.

A trained professional will promptly address your inquiry. If you are dissatisfied, the next step is to file a formal written grievance with Aetna.

Aetna will acknowledge, review and decide the grievance/complaint within 30 days from the date of receipt of the written grievance. A written notice stating the result of the review will be sent to you. You may appeal a determination to the Grievance/Appeal Committee.

If you file a claim and it is partially or totally denied, you can appeal the denied claim within 90 days after the date you are notified that your benefits have been denied. Be sure to state the reason you believe your claim has been improperly paid or denied and submit any pertinent information that could support your claim.

Your right to appeal a denied claim

Time Frame for Initial Claim Determination

For urgent care claims and pre-service claims (claims that require approval of the benefit before receiving medical care), the plan administrator will notify you of its benefit determination (whether adverse or not)

within the following time frames:

- 72 hours after receipt of a claim initiated for **urgent care** (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification)
- 15 days after receipt of a **pre-service claim**.

For **post-service claims** (claims that are submitted for payment after receiving medical care), the plan administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For **urgent care**, if you fail to provide the plan administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the plan administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The plan administrator's receipt of the requested information
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For **pre- and post-service claims**, a 15-day extension may be allowed to make a determination, provided that the plan administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the plan administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for **pre- and post-service claims** due to your failure to submit necessary information, the plan's time frame for making a benefit determination is stopped from the date the plan administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fail to follow the plan's procedures for filing a **pre-service claim**, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving **urgent care**) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters
- Is a communication that names you, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

Urgent Care Claims

Urgent care claims are those which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the

patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a plan amendment or plan termination.

If You Receive an Adverse Benefit Determination

The plan administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific plan provisions on which the benefit determination is based
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
- A description of the plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
- If the adverse benefit determination concerns a claim involving **urgent care**, a description of the expedited review process applicable to the claim.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
 - Was relied upon in making the benefit determination
 - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
 - Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination
 - Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for **urgent care**, an expedited review process in which:
 - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
 - All necessary information, including the plan's benefit determination on review, will be transmitted between the plan and you by telephone, facsimile, or other available similarly prompt method.

Ordinarily, a decision regarding your appeal will be reached within:

- 72 hours after receipt of your request for review of an **urgent care claim**
- 30 days after receipt of your request for review of a **pre-service claim**
- 60 days after receipt of your request for review of a **post-service claim**

The plan administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination
- References to the specific plan provisions on which the benefit determination is based

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Right of recovery

If for some reason a benefit is paid that exceeds the benefits provided by the Aetna HMO plan or a benefit was paid that did not legally have to be paid by you or a covered family member the plan has a right to recover the excess amount from the person or agency that received it.

When coverage ends

If you die while covered

If you die while covered by the University, your surviving dependents may be eligible for special survivor coverage. Certain requirements must be met for them to be eligible for continued coverage. Your dependents:

- must be covered under your plan at the time of death

For more information, please refer to www.nyu.edu/HR and refer to Policies.

If the University ends the benefit

The University has established the plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain the plan for any given length of time, and may at any time amend or terminate the plan, in whole or in part, with respect to any or all of its participants and/or beneficiaries. Any such amendment or termination shall be effected by a written instrument signed by an officer of New York University, or an authorized delegate. No vested rights of any nature are provided under the plan.

When coverage ends

Your Aetna HMO coverage ends on any one of the following:

- the day before the day your coverage begins under another NYU medical plan option
- the day before the first day of any month for which you fail to make your contribution for the cost of coverage under the Plan
- the day the plan ends
- the last day of the month in which you no longer meet eligibility requirements

Your spouse's coverage ends when any one of the following occurs:

- the day before the first day of any period for which you fail to enroll your dependent for coverage under the plan
- the day your dependent's coverage under the plan ends due to a qualifying status change
- the last day of the month in which you die, unless your dependent qualifies for survivor benefits through NYU
- the day before the day on which your dependent becomes an employee of NYU and is eligible for medical coverage under one of NYU's other health plans
- the day dependent coverage under this plan ends

Your dependent child's coverage ends on any one of the following:

- the day before the first day of any period for which you fail to enroll your dependent for coverage under the plan
- the day your dependent's coverage under the plan ends due to a qualifying status change
- the last day of the month in which you die, unless your dependent qualifies for survivor benefits through NYU
- the day before the day on which your dependent becomes an employee of NYU and is eligible for

medical coverage under one of NYU's other health plans

- the day dependent coverage under this plan ends

COBRA

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, which requires continuation of medical coverage to certain eligible employees whose coverage would otherwise terminate. If this section is incomplete or in conflict with the law, the terms of the law will govern.

Continuation of coverage

COBRA coverage also is available to your covered dependents if their coverage would otherwise end because of one of the following:

- your death
- your divorce, legal separation or annulment of your marriage
- Medicare entitlement
- your dependent child becomes ineligible for coverage

COBRA coverage continues for up to 18, 29 or 36 months, depending on how you or your eligible dependents become eligible. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars.

If you are disabled as determined by the Social Security Administration, you may elect to continue COBRA for up to 29 months and pay 102% of the cost for coverage.

Length of COBRA coverage

18 months

29 months

36 months (for dependents)

Reason coverage stops

You transfer to a position that is not eligible for medical benefits

The Social Security Administration determines that you or your dependent was permanently disabled at any time within the first 60 days of continuation coverage.

You or your dependents provide notice of the Social Security Administration's determination within 60 days of receiving it.

You die
You become entitled to Medicare
Your dependent stops being eligible for coverage
You divorce or legally separate

Electing COBRA

You and your covered dependents will receive election forms and more information about COBRA from EBPA, the COBRA billing administrator for New York University. In the case of a divorce, legal separation, or the ineligibility of a dependent child, you or your covered dependents must notify the NYU Benefits Office within 60 days of becoming eligible to elect COBRA.

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your University coverage ends or 60 days after the date of the notice of COBRA rights and your election is mailed to you by EBPA, whichever is later. You must pay any cost necessary to avoid a gap in coverage within 45 days of the date you elect COBRA.

If you elect COBRA coverage and the Social Security Administration determines that you or your covered dependent was permanently and totally disabled at any time within the first 60 days of the date of continuation coverage, you or your covered dependent must notify EBPA within 60 days of the determination. The notice must be received by EBPA within the initial 18 months of COBRA coverage so that you and your dependents can qualify for an additional 11 months of coverage.

If a 36-month event happens while a dependent is covered under COBRA, COBRA coverage may be continued for the dependent for another 18 months - up to a total of 36 months.

Required notices from qualified beneficiaries

To elect COBRA continuation coverage, you or your covered dependents are required to notify the NYU Benefits Office in writing within a maximum of 60 days after any of the following qualifying events:

- your divorce or legal separation
- your dependent child becomes ineligible for coverage

If you have elected continuation, you or your covered dependents are also required to notify EBPA in writing within a maximum of 60 days after any of the following:

- a second qualifying event such as divorce, legal separation, death or dependent child ceasing to be a dependent, or Medicare entitlement
- Social Security Administration determination of disability
- Social Security Administration determination of cessation of disability

The notification must include:

- name
- relationship to the employee
- a description of the qualifying event

When COBRA ends

COBRA coverage ends when one of the following events occurs:

- the COBRA period - 18, 29, or 36 months - ends
- premiums are not paid on a timely basis
- NYU stops offering any group health plan
- the person who elected COBRA becomes covered under another group medical plan and meets any **pre-existing condition** prohibitions or limitations
- the person who elected COBRA becomes entitled to **Medicare** after COBRA coverage has started

Conversion rights

If you or your eligible dependents do not elect COBRA coverage when eligible, you may convert to a different individual policy within 45 days after coverage ends. You should contact Aetna directly for more information.

If you elect COBRA coverage, you or your eligible dependents may arrange for conversion, if available, without providing proof of good health, after COBRA coverage ends.

Premiums for the converted policy are determined by the insurance company and are based on your level of coverage.

Administrative information

The information presented in this summary plan description is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA).

If there is any inconsistency between the SPD and the plan document, the plan document governs.

Subrogation

If you receive reimbursement from a third party for covered expenses as a result of legal action taken to recover your loss, which was due to negligence, wrongful acts, or omissions, Aetna reserves the right to repayment of benefits paid for the same covered expenses.

In addition, if you or your covered family member suffers an injury or sickness as a result of a negligent or wrongful act or omission, Aetna reserves the right to seek reimbursement (where permitted by law) from that third-party for benefits it paid for covered expenses. In such case, you are obligated to provide Aetna with any information necessary to enforce its rights under this provision.

ERISA rights

As a participant with Aetna HMO coverage, you are entitled to certain rights and protections under ERISA. ERISA entitles you to:

- examine, at the plan administrator's office and other specified locations, including work sites and union halls, if applicable, without charge, all plan documents governing the plan. These documents may include insurance contracts, collective bargaining agreements and the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain, after sending a written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. You may be asked to pay a fee for the copies.
- receive a written summary of the plan's annual financial report. The plan administrator is required by law to provide each participant with a copy of this summary annual report.
- continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your

group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request COBRA continuation coverage before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties on the people responsible for the operation of the plan. The people who operate your plan, called "fiduciaries," have a duty to do so prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack of decision about the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about your plan, contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan sponsor

New York University

c/o NYU Benefits Office

7 East 12th Street, 2nd Floor

Campus Mail Code: 8923

New York, NY 10003-4475

Phone: (212) 998-1270 (M-F 9am-5pm)

Email: benefits@nyu.edu

Web site: www.nyu.edu/hr

NYU Benefits Resource Center: www.home.nyu.edu

Plan name

Aetna HMO, a component of the New York University Health and Welfare Plan

Type of administration

Third Party Administration

Plan administrator

The plan administrator has the authority to control and manage the operations and administration of each plan. You can reach the administrator at:

Aetna

Group # SI 139423

980 Jolley Rd.

P.O. Box 1125

Blue Bell, PA 19422-0089

Phone: (800) 323-9930

www.aetna.com

Employer Identification Number (EIN)

The EIN is 13-5562308.

Plan number

The plan number is SI 139423.

Plan year

The plan year is January 1 to December 31.

Source of benefits funding

You and NYU pay the cost.

Agent for service of legal process

Office of Legal Counsel

New York University

Elmer Holmes Bobst Library

11th Floor

70 Washington Square South

New York, NY 10012

Pharmacy network

Caremark, Inc.
P.O. Box 659529
San Antonio, TX 78265-5529
Phone: (800) 421-5501
www.caremark.com
customerservice@caremark.com

Mail order prescription drug provider

Caremark Mail Order Pharmacy
P.O. Box 659529
San Antonio, TX 78265-5529
Phone: (800) 421-5501
www.caremark.com
customerservice@caremark.com

Mental health and Substance abuse network

Aetna Inc.
980 Jolly Rd.
P.O. Box 1125
Blue Bell, PA 19422-0089
Phone: (800) 323-9930
www.aetna.com

Contacts

For COBRA

EBPA
P.O. Box 1150
Exeter, NH 03833-1150
Phone: (800) 258-7298
Or
NYU Benefits Office
7 East 12th Street, 2nd Floor
Campus Mail Code: 8923
New York, NY 10003-4475
Phone: (212) 998-1270 (M-F 9am-5pm)
Email: benefits@nyu.edu
Web site: www.nyu.edu/hr
NYU Benefits Resource Center: www.home.nyu.edu

For converting your coverage

Aetna

Group # SI 139423

980 Jolley Rd.

P.O. Box 1125

Blue Bell, PA 19422-0089

Phone: (800) 323-9930

To locate participating providers in the Aetna HMO Standard network

Log on to www.aetna.com if you are enrolled the plan,

Call Aetna Member Services at (800) 323-9930

Getting preapproval for mental health and substance abuse

Aetna, Inc. Member Services

Phone: Please use the telephone number on your ID card

Issues with claims

Aetna, Inc. Member Services

Phone: Please use the phone telephone number on your ID card

Mail-order program

Caremark Mail Order Pharmacy

P.O. Box 659529

San Antonio, TX 78265-5529

Phone: (800) 421-5501

Prescription drug network provider

Caremark, Inc.

P.O. Box 659529

San Antonio, TX 78265-5529

Phone: (800) 421-5501

www.caremark.com

customerservice@caremark.com

The following terms are highlighted throughout the SPD as having definitions. In this section, you will find the definitions for these terms to help clarify their meaning and to provide information to better help you understand the provisions of your benefit plans.

Definitions

Adverse benefit determination

Any of the following that results in the denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit:

- Based on determination of a participant's or beneficiary's eligibility to participate in a plan
- Resulting from the application of any utilization review
- Failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate
- Restrictions on reimbursements for services because classified as nervous or mental

After-tax premium deductions

Contributions taken from your pay after applicable federal, state and local taxes are withheld.

Alternate facility

A health care facility that is not a hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services,
- emergency health services, or
- rehabilitative, laboratory, diagnostic, or therapeutic services.

An alternate facility may also provide mental health services or substance abuse services on an outpatient or inpatient basis.

Brand-name drug

Protected by a patent issued to the original company that invented or marketed the drug.

Certificate of coverage

Documentation confirming your last 18 months of health coverage that can help you get coverage without a pre-existing condition exclusion.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Federal law that allows eligible people covered by a group health plan to temporarily extend coverage when their coverage would otherwise end, such as when they get divorced or leave employment.

Coinsurance

A percentage of expenses that you are responsible for paying after you meet your deductible.

Copay

The flat dollar amount you pay for a certain type of health care expense.

Custodial care

General assistance in performing the activities of daily living, as well as board, room and other services, generally provided on a long-term basis and that do not include a medical component.

Deductible

The amount of out-of-pocket expenses you must pay for service before the plan pays any expenses.

Disability

A condition that causes you to be unable to perform one or more regular job duties.

Discounted fees

Lower fees charged for certain services received through network providers. The plan negotiates these lower fees with providers and facilities affiliated with the claims administrator's network.

Domestic partners

Two people who:

- agree to be jointly responsible for each other's common welfare and to share financial obligations
- live together in a long-term relationship of indefinite duration
- are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside

To apply for coverage for your domestic partner, register your domestic partner with the NYU Benefits Office.

Effective date

The earliest of:

- the date coverage begins
- the first day after the plan's waiting period

Employee

A person the University hires to do a job or activities that are controlled by the University (when, where and how to do the job).

Family and Medical Leave Act (FMLA)

Job protection and limited benefits for up to 12 weeks if you are seriously ill or injured, for the birth, adoption or foster care placement of a child, to care for the child, or to care for a sick spouse, child or parent.

Family deductible

The family deductible is an amount of money that you must pay out-of-pocket before your insurance will cover expenses. The deductible can be satisfied by the combined expenses of all covered family members. For example, a program with a \$100 deductible may limit its application to a maximum of three deductibles (\$300) for the family, regardless of the number of family members. Once the family deductible is met, no other covered member needs to satisfy the full individual deductible. An aggregate family deductible may be met by one or more family members.

Full-time

Employees who are scheduled to work for the University for the full, normal work week.

Generic drug

A drug that generally contains the same ingredients and has the same effect as a brand-name drug,

but is manufactured by a company other than the one that manufactures the brand-name drug.

Group health coverage

Health plans designed to provide benefits to a specific group of people, like a University, union or professional organization.

Hospital

An institution rendering inpatient and outpatient services for the medical care of the sick or injured. It must be accredited as a hospital by either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the American Osteopathic Association. A hospital may be a general, acute care or specialty institution provided that it is appropriately accredited as such, and currently licensed by the proper state authorities.

Individual deductible

The amount of covered expenses each covered individual is responsible for paying each year before the plan starts paying certain benefits.

Inpatient

When you are admitted to the hospital and stay more than 24 hours.

In-network provider

A doctor, hospital, or other health care professional facility affiliated with the network.

Medical identification card

A card your health plan sends you that contains information your physician needs to process your medical expenses.

Medically Necessary

Services and supplies that are performed in a cost-efficient manner to meet the basic health care needs of you and your covered family members, as determined by the claims administrator. Treatment is considered medically necessary if care or treatment is likely to produce a significant positive outcome, result in information that could affect the course of treatment, and is no more costly (taking into account all health expenses incurred in connection with the treatment) than any alternative treatment for the disease or injury involved. In determining whether a treatment is medically necessary, the claims administrator considers the following:

- information that is provided on the covered person's health status,
- reports in peer-reviewed medical literature,
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, and treatment
- the opinion of health professionals in the general recognized health specialty involved, and
- any other relevant information brought to the claims administrator's attention

Medicare

The U.S. federal government's plan, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those over 65 or totally and permanently disabled. Benefits are provided regardless of income level. The program is government subsidized and government operated.

Notification date

When you are told about an event related to your benefits. Also, the date you notify the plan administrator of an event that may result in a change in election, such as marriage.

Open enrollment

The period of time each year designated by the University when you may generally make changes to your benefit elections, if allowed by the plan.

Out-of-network provider

A doctor, hospital, or other health care professional or facility that is not a member of the network.

Out-of-pocket maximum

The maximum amount you have to pay toward the cost of your medical care in the course of one year. There are some exceptions to the out-of-pocket maximum.

Outpatient

When you visit a clinic, emergency room or health facility and receive health care without being admitted as an overnight patient.

Part-time

Employees who are scheduled to work less than the normal work week.

Physician

Any Doctor of Medicine, 'M.D', or Doctor of Osteopathy, 'D.O.', who is properly licensed and qualified by law. Any podiatrist, dentists, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a physician. The fact this plan describes a provider as physician does not mean that benefits for services from that provider are available to you under the plan.

Post-service claim

Claims that involve only the payment or reimbursement of the cost of medical care that has already been provided, and any other claims for benefits that is not a pre-service claim, for example, claims for reimbursement for already performed diagnostic tests.

Pre-certification

Authorization you may need to receive full benefits.

Pre-existing condition

A health problem you had and received treatment for before your current benefit elections took effect.

Pre-service claim

Any claim for a benefit with respect to the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Primary care physician (PCP)

A doctor you choose who is responsible for coordinating your medical care, from providing direct care to referring you to specialists and hospital care.

Primary plan

The plan that covers you first when you have coverage under more than one plan.

Qualified Medical Child Support Order (QMCSO)

A judgment, decree or order that meets all of the following criteria:

- is issued by a court pursuant to a domestic relations law or community property law
- creates or recognizes the right of an alternate recipient to receive benefits under a parent's

employer's group or health plan

- includes certain information relating to the participant and alternate recipient

Qualifying status change

A qualifying status change occurs when: your marital status changes (or you register or revoke a domestic partnership), you increase or decrease your number of dependents (birth, death, adoption or placement for adoption, guardianship, permanent or temporary custody of a child), your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age 19 or 25 if a full-time student or marries), a court decree that orders you must provide health coverage for your dependent, your or your dependent's work site changes, your or your dependent's residence changes, your dependent's Medicare/Medicaid eligibility status changes, your spouse's/partner's employer's plan has a different plan year and open enrollment period than NYU's, coverage under your spouse's/partner's plan is significantly curtailed or ceases, your spouse's/partner's employer adds new health plan options, NYU adds new health plan options, your provider of dependent care changes, your cost for dependent care significantly increases or decreases, or you or your spouse/partner commences or returns from an FMLA leave.

The term "dependent" refers to any of the following as defined by the plan: your spouse, your domestic partner that you have registered with the NYU Benefits Office, your child, your step-child, your adopted child or child placed with you for adoption, or the child of your registered domestic partner, a child for whom you have been appointed legal guardian, a child for whom you have been awarded permanent or temporary custody.

Reasonable and customary (RC) charges

R&C charges are set by the claims administrator, and apply to covered services. R&C charges are based on the typical charge made by most providers for similar services or supplies in your geographic area. If the charge for services or supplies is more than the R&C limit set by the claims administrator, you pay the portion above the R&C limit for any service covered by the plan for which R&C applies in determining the benefit you receive.

Regular employee

An exempt or non-exempt employee who works on an ongoing basis instead of a temporary basis.

Reimburse

When you are paid back for money you spend on approved expenses.

Secondary plan

The plan that is second in responsibility under coordination of benefits when you have coverage under more than one plan.

Section 125

A section of the Internal Revenue Code that allows you to pay for certain benefits with pretax dollars, and regulates enrollment and eligibility requirements for these benefits.

Service area

The geographic area established by this plan and approved by the regulatory authority, in which you must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in this plan.

Specialist

A physician who practices in a certain area of medicine like surgery, obstetrics or gynecology rather than dealing with all aspects of your health.

Spouse

Your husband or wife, married to you in a civil or ecclesiastical ceremony.

Termination date

The last day you are scheduled to work.

Total disability

An illness or injury that prevents you from continuously performing every duty pertaining to your job or from engaging in any other type of work for pay.

Urgent care claim

Claims for medical care or treatment that if processed under normal claims decisions could seriously jeopardize the claimant's life or health, jeopardize claimant's ability to regain maximum function, or subject claimant to severe pain that cannot be managed without the care or treatment that is the subject of the claim.