

**AMERICAN INSTITUTE OF PHYSICS
MEDICAL PLANS 2010**

BENEFITS	Aetna - NY & MD Choice PPO- Current Plan		Aetna - NY Choice- POS Flex		HIP NY HMO
	Member's Responsibility		Member's Responsibility		Member's Responsibility
	In Network	Out of Network	In Network	Out of Network	In Network Only
PHYSICIAN SERVICES					
Physician Office Visits					
Annual Deductible	\$100/\$200	\$600/1,200	None	\$1,000/\$2,000	None
Your Co-pay (Primary/Spec.)	\$25/\$40	20% after Ded	\$25/\$40	20% after Ded	\$10/\$10
Annual OP Max.(Incl. Ded.)	N/A	\$1,500/\$3,000	\$1500/\$3000	\$5,000/\$10,000	N/A
Maternity - Your Co-pay	Copay 1st visit only	20% after Ded	\$25/\$40/1X then none	20% after Ded	Covered in Full
Outpat Surg.	\$150 co-pay	\$150 + 20% after Ded	\$250 copay	20% after Ded	Covered in Full
Allergy Tests/Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered.				
Your Co-pay		20% after Ded	\$25/\$40	20% after Ded	Covered in Full
Preventive Care					
Annual Physical	\$25/\$40	20% after Ded	\$25/\$40	Not Covered	\$10
Mammography	Covered in Full	20% after Ded	\$25/\$40	Covered in Full	\$10
Well Child Care	\$25/\$40	20% after Ded	Covered in Full	Covered in Full	None to age 19
Immunizations/Screening	\$25/\$40	20% after Ded	\$25/\$40	20% after Ded	\$10
Pap Smears	\$25/\$40	20% after Ded	\$25/\$40/1X/yr	Not Covered	\$10
Ment. Health/Subst. Abuse	combined in/out of network				
Inpatient Coverage	100% after \$500 per confinement copay	\$500 per confinement copay, 20% after Ded	Biologically Based MH - \$500 copay unlimited visits. Non-Biologically Based MH - \$500 copay	20% after Ded	MH - Covered in Full; 30 days per calendar year Subst. Abuse - No Copay; 30 days per calendar
Partial Hospitalization	100% after Deductible	20% after Ded			
Partial Hospitalization Max.					No Co-Pay with 60 visits/yr max
Outpatient Coverage	100% for all visits in a calendar year	Covered Same as specialist office visit after deductible	\$40 copay per visit	20% after the deductible	MH - No Co-Pay with 60 visits/yr max Subst. Abuse - \$10 copay; 60 visits per calendar yr
Phys, Speech & Occ. Ther.					
Your Co-pay	Covered in Full	20% after Ded	\$25/\$40	20% after Ded	\$10
Annual Maximum	Treatment of cleft lip, cleft palate, orthodontics, oral surgery, otologic, audiological, speech therapy, physical therapy, and occupational therapy for covered children in conjunction with congenital or genetic birth defects combined 120 visits		120 visits	120 visits	90 visits per year
Durable Medical Equipment					
Your Co-pay	Covered in Full	Covered in Full	Covered in Full	20% after Ded	Appliances Covered in Full
HOSPITAL SERVICES					
Semi-Private Room & Board					
Your Co-pay	\$500	\$500 copay & 20% after Ded	\$500	20% after Ded	Covered in Full
Emergency Room	\$150 co-pay/vis. waived if admitted within 24 hours	\$150 co-pay/vis. waived if admitted within 24 hours	\$150 co-pay/visit waived if admitted within 24 hours	\$50 co-pay/visit waived if admitted within 24 hours	Covered in Full
Hospice Care (In&Outpat.)	Inpatient limited to 30 days per lifetime				
Your Co-pay	\$500 inpatient copay; Outpatient covered in full	\$500 copay & 20% after Ded	\$500 copay/100%	20% after Ded (\$10,000 lifetime max combined in and outpatient)	Covered in Full 210 days
OTHER BENEFITS					
Skilled Nursing Facility					
Your Co-pay	Covered in Full	20% after Ded	\$500	20% after Ded	Covered in Full
Annual Maximum	Limited to 70 eight hour shifts per calendar year		Covered in Full	Limited to 240 days and 35 visits	Unlimited days
Home Health Care	combined 120 days/yr				
Your Co-pay	Covered in Full	Covered in Full	\$15 copay	20% after Ded	200 visits/year
Chiropractic Care					
Your Co-pay	Covered in Full	20% after Ded	\$40 copay/V, 20 visits	20% after Ded/\$1000 calendar yr max except NY	\$10 copay/No Maximum
Prescription Drugs					
Your Co-pay (Retail)	\$15generic/\$25brand/\$40nonform		\$15generic/\$25brand/\$40nonform		\$5 generic/\$5 brand form only
Mail Order Co-pay (90 day)	\$30 generic/\$50 formulary/\$80 non formulary		\$30 generic/\$50 formulary/\$80 non formulary		Mail Order Available
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	\$1,000,000	Unlimited

IN THE CASE OF ANY DISCREPANCY BETWEEN THIS SUMMARY AND THE SUMMARY PLAN DESCRIPTION (SPD),
THE SPD WILL SUPERCEDE