Aetna Healthy New York Plan

Plan Overview

Use this information to:

- Evaluate plan benefits and rates
- Determine whether you are eligible for enrollment in the Healthy New York plan
- Apply for enrollment

As the employer of a small group, you will need to decide whether to offer your employees the plan with or without coverage for pharmacy benefits.

Should you decide you want to apply for coverage in the Healthy New York plan:

- Download, complete and sign the Employer Application at **www.dfs.ny.gov/website2/hny/english/hnystapp.htm**.
- Review the Healthy New York rates schedule at **www.dfs.ny.gov/website2/hny/english/hnyr.htm** to determine the applicable monthly premium for each subscriber in the group. Determine your total initial monthly premium. Remember to indicate whether you are choosing the plan with pharmacy benefits or without pharmacy benefits.

A check for the full first month's premium, made payable to Aetna, must be returned, along with the Healthy New York application, to:

Aetna
Healthy New York
3 Independence Way, 4th floor
Princeton, NJ 08540

If we receive a properly completed application and first month's premium between the 1st and 20th of the month, group coverage will be effective on the first of the following month. If we receive a properly completed application and first month's premium between the 21st and 31st of the month, group coverage will be effective the first of the month, following 30 days.

If upon receipt and review of your application, the group is determined ineligible for the Healthy New York plan, we will return payment, along with a letter indicating the reason the group was determined ineligible.

If you have additional questions as you review the material and complete the forms, please don't hesitate to call us at **1-866-386-1371**. A plan representative will be available to assist you.

The Healthy New York Plan is underwritten by Aetna Health Inc. (Aetna).

14.02.319.1-NY A (1/12)

Plan Features	High-Deductible Health Plan (HDHP)
Deductible	$1,200 individual/$2,400 family
Out-of-Pocket Maximum (includes deductible and applicable copayments)	The maximum out-of-pocket expense for individuals is $6,050 The maximum out-of-pocket expense for family coverage is $12,100
Primary Care Physician Visit	
Office Hours	Deductible/$20 copayment
After-Hours/Home	Deductible/$20 copayment
Specialist Care	
Office Visits	Deductible/$20 copayment
Diagnostic Outpatient Lab/X-ray Testing (at facility)	Deductible/$20 copayment
Diagnostic Outpatient Lab/X-ray Testing (at specialist)	Deductible/$20 copayment with PCP referral
Surgical Services (including breast reconstruction following a mastectomy)*	Deductible/20% or $200, whichever is less
Outpatient Therapy (speech and occupational)	Not covered
Outpatient Therapy (physical)**	Deductible/$20 copayment per visit, 30 visit maximum per calendar year
Outpatient Dialysis/Chemotherapy	Deductible/$20 copayment
Allergy Testing/Treatment	Not covered
Preventive Care	
Routine Physicals	No deductible or copayment Adults age 22 and over – 1 visit every 24 months
Routine Prostate Cancer Screening	No deductible or copayment
Well-Baby and Well-Child Care; Immunizations; Physical Exam	No deductible or copayment 7 exams in the first 12 months; 3 exams in the second 12 months of life; 3 exams in the third 12 months of life; 1 exam per year thereafter through age 21.
Routine GYN Care	No deductible or copayment. Up to 2 annual exams for primary and preventive obstetric and gynecologic care; and care required as a result of the annual examination or as a result of an acute gynecological condition.
Routine Mammography	No deductible or copayment. Upon the recommendation of a physician, a mammogram at any age if prior history of breast cancer or if mother or sister has a prior history of breast cancer A single baseline mammogram for women aged 35 – 39 An annual mammogram for women aged 40 and older
Routine Vision (Eye) **Exam**	Not covered
Pediatric Dental	Not covered
Hearing Exam	Not covered
Hearing Aids	Not covered
Emergency Care	Deductible/$50 copayment, waived if admitted to hospital
Urgent Care Out-of-Area	Deductible/$50 copayment
Ambulance	Not covered
Outpatient Surgery (Facility)*	Deductible/$75 facility copayment
Hospitalization (Facility)*	Deductible/$500 facility copayment per continuous confinement
Skilled Nursing Facility Care (in lieu of hospitalization for medically necessary covered benefits)	Not covered

Plan Features	High-Deductible Health Plan (HDHP)
Maternity	
OB Visits	No deductible/$10 copayment per visit for prenatal care Deductible/$10 copayment for postnatal visit
Hospital (Includes Newborn Services)*	Deductible/$500 facility copayment per continuous confinement
Home Health Care**	Deductible/$20 copayment per visit, 40 visit maximum per calendar year
Private Duty of Special Duty Nursing	Not covered
Hospice — Inpatient	Not covered
Family Planning/Reproductive Services **Sterilization Procedures**	Not covered
Mental Health	
Inpatient	Not covered
Outpatient	Not covered
Substance Abuse Detoxification	
Inpatient Detoxification	Not covered
Outpatient Detoxification	Not covered
Substance Abuse Rehabilitation	
Inpatient Rehabilitation	Not covered
Outpatient Rehabilitation	Not covered
Chiropractic Care	Not covered
Diabetic Supplies (NY Mandate – effective 1/1/94)	Deductible/$20 copayment per visit for self-management education Deductible/$20 copayment per each item of equipment Deductible/$20 copayment per 34-day supply of insulin, hypoglycemics and supplies
Pharmacy	
Prescription Drugs Note: The choice to have a prescription drug rider is made at the time of the initial application. That selection will be in effect for a 12-month period. Adding or removing the prescription drug rider can only be done upon recertification.	**Copayments:** Deductible/$10 copayment per generic drug per 34-day supply; Deductible/$20 copayment per brand-name drug plan difference in cost between the brand-name drug and its generic equivalent per 34-day supply **Mail-Order Delivery (MOD):** Deductible/$20 copayment per generic drug per 90-day supply; $40 per brand-name drug per 90-day supply plus difference in cost between brand-name and its generic equivalent

*Surgical services — (20% or $200, whichever is less) This copay/coinsurance is in addition to any inpatient hospitalization facility, outpatient facility and inpatient maternity facility copay. Includes breast reconstruction following a mastectomy.

**Only covered following an inpatient hospital stay, surgery or emergency room (ER) visit. Physical therapy/home health care visits must be related to injury/illness for which the member received inpatient services, surgery or ER services.

If you require language assistance from an Aetna representative, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862. (140 languages are available. You must ask for an interpreter.) TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante de Aetna que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD 1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Health benefits and health insurance plans contain exclusions and limitations.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Information is believed to be accurate as of the production date; however, it is subject to change.

Available in Spanish. Disponible en Español.

www.aetna.com

©2012 Aetna Inc.
14.02.319.1-NY A (1/12)