

Thank you for your recent interest in the Healthy New York plan

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.ins.state.ny.us/website2/hny/english/hnystapp.htm.
- Review the Healthy New York rates schedule at www.ins.state.ny.us/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 Sales Support
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.

Plan Features	HMO Plan In-Network (Referred Care)	HMO/High-Deductible Health Plan (HDHP)
Deductible	N/A	\$1,150 individual/\$2,300 family
Out-of-Pocket Maximum (includes deductible and applicable copayments)	N/A	\$5,250 individual/\$10,500 family (a combination of covered family members)
Primary Care Physician Visit		
Office Hours	\$20 copayment	Deductible/\$20 copayment
After-Hours/Home	\$20 copayment	\$20 copayment
Specialist Care		
Office Visits	\$20 copayment	Deductible/\$20 copayment
Diagnostic OP Lab/X-ray Testing (at facility)	\$20 copayment	Deductible/\$20 copayment
Diagnostic OP Lab/X-ray Testing (at specialist)	Included in Specialist Office Visit copayment with PCP referral	Deductible/\$20 copayment with PCP referral
Surgical Services (including breast reconstruction following a mastectomy)*	20% or \$200, whichever is less	Deductible/20% or \$200, whichever is less
Outpatient Therapy (speech and occupational)	Not covered	Not covered
Outpatient Therapy (physical)**	\$20 copayment per visit, 30 visit maximum per calendar year	Deductible/\$20 copayment per visit, 30 visit maximum per calendar year
Outpatient Dialysis/Chemotherapy	\$20 copayment	Deductible/\$20 copayment
Allergy Testing/Treatment	Not covered	Not covered
Preventive Care		
Routine Physicals	\$20 copayment — 1 visit every 36 months	Deductible /\$20 copayment — 1 visit every 36 months
Routine Prostate Cancer Screening	\$20 copayment per visit, per year	Deductible waived \$20 copayment per visit, per year
Well-Baby and Well-Child Care; Immunizations; Physical Exam	No copayment	No deductible or copayment
Routine GYN Care	\$20 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	Deductible/\$20 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	\$20 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 A mammogram every 2 years, or more frequently upon the recommendation of a physician, for women aged 40 – 49 An annual mammogram for women aged 50 and older	Deductible waived/ \$20 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 A mammogram every 2 years, or more frequently upon the recommendation of a physician, for women aged 40 – 49 An annual mammogram for women aged 50 and older
Routine Vision (EYE) Exam	Not covered	Not covered
Pediatric Dental	Not covered	Not covered
Hearing Exam	Not covered	Not covered
Hearing Aids	Not covered	Not covered
Emergency Care	\$50 copayment, waived if admitted to hospital	Deductible/\$50 copayment, waived if admitted to hospital
Urgent Care Out-of-Area	\$50 copayment	\$50 copayment
Ambulance	Not covered	Not covered
Outpatient Surgery (Facility)*	\$75 facility copayment	\$75 facility copayment
Hospitalization (Facility)*	\$500 facility copayment per continuous confinement	\$500 facility copayment per continuous confinement
Skilled Nursing Facility Care (in lieu of hospitalization for medically necessary covered benefits)	Not covered	Not covered
Maternity		
OB Visits	\$10 copayment per visit for prenatal care \$10 copayment for postnatal visit	Deductible waived \$10 copayment per visit for prenatal care \$10 copayment for postnatal visit
Hospital (Includes Newborn Services)*	\$500 facility copayment per continuous confinement. 20% or \$200 copayment, whichever is less	\$500 facility copayment per continuous confinement. 20% or \$200 copayment, whichever is less

Home Health Care**	\$20 copayment per visit, 40 visit maximum per calendar year	Deductible/\$20 copayment per visit, 40 visit maximum per calendar year
Private Duty of Special Duty Nursing	Not covered	Not covered
Hospice — Inpatient	Not covered	Not covered
Family Planning/Reproductive Services Sterilization Procedures	Not covered	Not covered
Mental Health		
Inpatient	Not covered	Not covered
Outpatient	Not covered	
Substance Abuse Detoxification		
Inpatient Detoxification	Not covered	Not covered
Outpatient Detoxification	Not covered	
Substance Abuse Rehabilitation		
Inpatient Rehabilitation	Not covered	Not covered
Outpatient Rehabilitation	Not covered	
Chiropractic Care	Not covered	Not covered
Diabetic Supplies (NY Mandate – effective 1/1/94)	\$20 copayment per visit for self-management education \$20 copayment per each item of equipment \$20 copayment per 34-day supply of insulin, hypoglycemics and supplies	Deductible/\$20 copayment per visit for self-management education \$20 copayment per each item of equipment \$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.	Deductible: \$100 per individual per calendar year Copayments: \$10 per generic drug per 34-day supply; \$20 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): \$20 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 Benefit Maximum: \$3,000 per individual per calendar year	Copayments: \$10 per generic drug per 34-day supply; \$20 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): \$20 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 Benefit Maximum: \$3,000 per individual per calendar year

*Surgical services copay/coinsurance (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.

**Must be performed following surgery or a hospital confinement.

***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.

Translation of this material into another language may be available. For assistance, please call Member Services at 1-888-98-AETNA (1-888-982-3862).

Puede estar disponible la traducción de este material en otro idioma. Por favor, para ayuda llame a Servicios al Miembro al 1-888-98-AETNA (1-888-982-3862).

Please use the phone number mentioned on the individual document.

Health benefits 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 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 subject to change.

