

Individual Advantage HMO Plan

New York

The following benefits information supplements the applicable sections of the accompanying HMO benefits plan brochure.

Summary of Benefits and Out-of-Pocket Costs*

Benefits	Out-of-Pocket Costs
Primary Care Physician Visits	
Office Hours	\$15 copay
After-Hours/Home Visits	\$15 copay
Specialty Care	
Office Visit	\$15 copay
Diagnostic Outpatient Testing	\$15 copay
Outpatient Physical Therapy (90 visits per condition per year)	\$15 copay
Outpatient Surgery	\$75 copay
Hospitalization	\$500 copay per continuous confinement
Emergency Room	\$50 copay
Maternity	
First Ob Visit	No copay
Hospital	\$500 copay per continuous confinement
Delivery	20% up to \$200
Mental Health	
Inpatient Confinement	\$500 copay per continuous confinement, combined maximum of 30 days per calendar year**
Outpatient	10% per visit, 30 visits per calendar year, plus 3 emergency room visits per calendar year
Substance Abuse	
Detoxification	\$500 copay per continuous confinement, combined maximum of 30 days per calendar year**
Preventive Care	
Routine Eye Screening (in PCP's office)	\$0 copay
Routine Gyn Exam (one per 365 days)	\$0 copay
Immunizations	\$0 copay
Prescription Drugs See reverse side	
Durable Medical Equipment	No copay
Private Duty Nursing	\$15 per visit. Combined maximum for all inpatient and outpatient services of \$5,000 per member, per calendar year, \$10,000 per lifetime.

*Refer to your plan documents for a complete list of benefits, exclusions and limitations.

**Inpatient mental health and substance abuse days are a combined maximum and offset each other.

Additional information:

- All members must select a New York primary care physician. Female members have direct access to participating gynecologists who must also be located within New York.
- Call our customer service hotline at **1-800-435-8742** if you have questions about your plan.
- In order to keep your coverage, you will need to pay your monthly premium. You can mail your payment to Aetna, P.O. Box 41767, Philadelphia, PA 19101-1767. If you have a question about your payment, call Member Services at **1-800-435-8742**.
- Except for direct access or emergency care, all specialty and hospital services require a prior written referral from your primary care physician. See your plan documents for a complete list of terms, benefits and exclusions.

Prescription coverage

Medically necessary prescription drugs are covered subject to applicable limitations and exclusions. Take your prescription and Aetna ID card to any participating pharmacy to obtain covered prescription drugs. Each prescription is limited to a maximum 34-day supply. After you pay a calendar year deductible (\$100 for yourself or \$300 for your family), you will pay:

- \$5 copay for covered generic drugs
- \$10 copay for covered brand-name drugs



Prescription coverage (cont.)

Drugs on our Formulary Exclusions list are not covered unless a medical exception is obtained by your doctor.

The formulary is a list of prescription drugs that includes hundreds of generic and brand-name drugs covered by the plan (subject to applicable limitations and conditions) and approved by the Food and Drug Administration (FDA). In choosing drugs for our formulary, we first evaluate FDA, manufacturer and peer-reviewed literature regarding a drug's clinical safety and efficacy; then we consider its overall value. Generic drugs are deemed by the FDA to be the therapeutic equivalent to their brand-name counterparts. Generic drugs contain the same active ingredients in the same amount. You may pay less out-of-pocket for generic drugs. Review our formulary on our website at www.aetna.com. After you enroll, you will receive the Aetna Medication Formulary Guide, which lists our formulary medications. Our formulary is subject to change. As noted above, your coverage is not limited to drugs on the formulary.

Prescription drugs in the limitations section of your plan documents and nonprescription drugs are not covered, and medical exceptions are not available for them.

In an emergency, if you need to fill a covered prescription at a nonparticipating pharmacy located beyond a 50-mile radius of your HMO service area, you will need to pay the full charge for the prescription and submit a claim to Aetna. Your reimbursement, which is subject to professional review, is 100 percent of the cost of the prescription, less applicable deductible and copay. At a participating pharmacy outside of your HMO service area, present your ID card. After you have paid the calendar year deductible, you'll pay only the copayment.

Health benefits plans are offered and/or underwritten by Aetna Health Inc. (Aetna).

This material is for information only and is not an offer or invitation to contract. Plan features and availability may vary by location. Rates and benefits may vary by location. Health benefits plans contain exclusions and limitations. 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. Not all health services are covered. See health insurance plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug makers 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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional.

Information is believed to be accurate as of the production date; however, it is subject to change.

Pre-existing conditions and limitations

For a period of twelve (12) months following the date that an individual files a substantially complete application for coverage and before the first day of coverage, coverage is excluded for any service obtained by or on behalf of a member for conditions of the member (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received, during the six (6) months immediately preceding the enrollment date, or for a period of 10 months as to a pregnancy existing on the effective date of coverage. However, any time the member was previously covered under a previous health insurance plan or policy, health maintenance plan or employer-provided health benefit arrangement, if the previous coverage was continuous to a date of coverage, it shall be credited to the member. The pre-existing condition limitation will not apply if you:

- Just converted your coverage from an Aetna HMO group coverage benefits plan
- Or, are an "eligible individual" under the Health Insurance Portability and Accountability Act (HIPAA) (see section 2741[b] of the Federal Public Health Services Act). Refer to your plan documents for more information.
- Are a dependent child under age 19

What's not covered

Services and supplies not covered include, but are not limited to, the following:

- Pre-existing conditions as described above
- Services not referred by your primary care physician (except in an emergency and covered direct access services)
- Cosmetic surgery, including breast reduction
- Custodial care

- Hearing aids
- Experimental or investigational procedures or treatments
- Routine foot care
- Infertility services (except surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by this contract) including, but not limited to, in vitro fertilization procedures, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), unless specifically listed as covered in the plan documents
- Dental care or treatment or X-rays, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident, or care or treatment necessary due to congenital disease or anomaly
- Treatment of mental retardation
- Substance abuse rehabilitation
- Reduction of nails, calluses or corns
- Rehabilitation therapies (including, but not limited to, occupational, speech and cardiac therapy) except for physical therapy
- All medical and hospital services not specifically covered by the New York Individual Advantage HMO plan

See your plan documents for a complete list of exclusions.

Translation of this material into another language may be available. For assistance, please call Member Services at 1-800-435-8742/TDD 1-800-628-3323.

Puede estar disponible la traducción de este material en otro idioma. Por favor, para ayuda llame a Servicios al Miembro al 1-800-435-8742/TDD 1-800-628-3323.



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