Healthy NY Case Submission

Along with your signed and dated application, be sure to include **ONE** from each section listed below**.**

Proof of Residence

- ☐ Utility Bill less than 90 days old (electric, cable, telephone, cell...)
- ☐ Drivers License
- ☐ Lease
- ☐ Mortgage Statement

Proof of Self Employment

- ☐ 2010 signed 1040 Tax Form with attached schedule C, E or F
- ☐ Business Certificate

Did you remember to?

- Sign all forms where indicated
- Sign your 2010 1040 tax form Page 2 (both yourself and your spouse). This is one of the most overlooked items which slows down the enrollment process. Please make sure your copy is signed.
- Include your check made payable to "GHI"

Mail your application along with all of the above to

Vista Health Solutions, Inc.
Enrollment Dept.
PO Box 337
Suffern, NY 10901

Healthy NY Application Instructions

Confidentiality Statement: Information provided on this application will remain confidential and will only be disclosed to the staff at health plans and state agencies operating this program.

Section A: Applicant information

In this section, we ask how to contact you.

Section B: Coverage options

1. Benefits

Healthy NY offers a standardized benefits package, with an optional prescription benefit. Choose if you want Healthy NY with a prescription drug benefit or without a prescription drug benefit.

Once you choose the benefit option, you will not be able to change your selection until your annual recertification or at the time of a premium rate change.

2. Deductible

All plans are subject to an annual deductible. The deductible amount is the amount you must spend out-of-pocket before services are covered. Preventive care can be accessed prior to meeting the deductible. For 2012, the deductible is $1,200 for individuals and $2,400 for families. The deductible amount may change annually and we encourage you to visit our website at www.healthyny.com for more information.

Section C: Employment information

To be eligible for Healthy NY, either you or your spouse must have worked at some point within the past 12 months. Please answer the employment questions.

Section D: Health insurance information

Healthy NY is for people who have been without comprehensive health insurance for 12 months or who have lost their health insurance due to certain specific events. Please answer the questions in Section D regarding prior health insurance coverage. Canceling other insurance due to cost does not entitle you to coverage.

Section E: Household income

In order to qualify for Healthy NY, your household income must fall within the limits set by law. Please list your current gross (before taxes) monthly income and the current gross monthly income of your spouse (if residing in your household). No one else's income is counted.

2011 Healthy NY Monthly Income Guidelines

PERSONS IN FAMILY	GROSS INCOME
1	Up to $2,269
2	Up to $3,065
3	Up to $3,861
4	Up to $4,657
5	Up to $5,453
6	Up to $6,248
Each Additional Person	Add $796

Pregnant women count as two people.
Income levels are updated annually.

Section F: Household Members

Please complete the chart in Section F. Include information for yourself, your spouse and your children. If you are a sole proprietor, you may include information about your domestic partner, if applicable. Spouses and domestic partners must reside in your household. Do not count other people residing in your household, such as parents, roommates, etc.

Section G: Documentation

Documentation of NYS residence, employment status, and household income must be included with your application. Submit documentation of current income such as your most recent pay stubs. You must include documentation that shows your income for the last month. If this information is not available or not representative of your normal income, submit your tax return or business documentation and provide an explanation of the documentation.

Section H: Certification

Please carefully review and complete the certification set forth in Section H.

Submitting Your Application **Detach and send your completed applications directly to the HMO or participating insurer that you choose. For a list of HMOs and participating insurers and their addresses and rates, go to www.HealthyNY.com and select the link "HMOs and Rates by County." Applicants whose completed applications are received by the 20th of the month may be enrolled by the 1st of the following month. For faster processing, include a check for the first month's premium, made payable to the HMO or participating insurer. If you have questions, or to check the status of your application, please call your chosen HMO or participating insurer directly.**

Healthy NY Application for Individuals and Sole Proprietors

Section A: Applicant information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss Male ☐ Female ☐

Name: First _____ Middle Initial _____ Last _____

Telephone: Home _____ Work _____

Street address of person applying for coverage:

Street _____

City _____ State NY ZIP _____ County _____

Mailing address if different then street address

Street **Same As Above**

City _____ State _____ ZIP _____ County _____

Section B: Coverage Options

Healthy NY is available with or without prescription drug coverage. Premiums are higher for coverage with a drug benefit. All Healthy NY coverage options have a deductible of $1,200 for individual coverage ($2,400 for family coverage) for 2012. Preventive services are covered before meeting the deductible.

Please select your coverage option:

☐ Healthy NY with drug coverage

☐ Healthy NY without drug coverage

Section C: Employment Information

1. Please indicate whether you are applying as an individual or as a sole proprietor. A sole proprietor is someone who is the sole owner and only employee of a business, regardless of the business's format.

   ☐ Individual

   ☐ Sole proprietor – You will be asked to submit proof of self-employment

2. You can qualify for Healthy NY if either you or your spouse worked during the past 12 months. Please answer the following questions about employment:

Who is currently employed?	☐ You	☐ Spouse	☐ Neither
Who has worked in the past 12 months?	☐ You	☐ Spouse	☐ Neither

If both questions above are answered "Neither," then you will not qualify for Healthy NY.

Section D: Health insurance information

Healthy NY is available to individuals who have not had comprehensive (medical **and** hospital) health insurance coverage in place during the past 12 months or have lost their insurance due to certain reasons. Please answer the following questions:

1. Have you had health insurance coverage that included both medical and hospital benefits during the past 12 months? Note: Answer "Public Program" if your coverage was through Medicaid, Child Health Plus, Family Health Plus, Healthy NY, or another public health program.

❑ Yes ❑ No ❑ Public Program

Name of Public Program _____

2. If you have had comprehensive health insurance coverage during the past 12 months, please indicate the reason(s) for termination. Please check all that apply.

- ❑ Losing employment
- ❑ Changing to a new employer, leaving the workforce, or retiring
- ❑ Changing residence
- ❑ Death of a family member
- ❑ Legal separation, divorce, or annulment
- ❑ Reaching the maximum age under your policy
- ❑ Losing eligibility for group health insurance coverage
- ❑ Discontinuing a group health insurance plan
- ❑ Terminating or canceling COBRA/continuation coverage

3. Date coverage terminated or will terminate due to reason noted in 2.

_____/_____/_____

Section E: Household income

Income limitations are set by law. Please list your current monthly **gross** income and the current monthly **gross** income of your spouse (if residing in your household). Gross income is before taxes. Income includes salary, wages, commissions, royalties, alimony received, self-employment income, rental income, interest and dividends from investments and accounts, public or private retirement or pension benefits, Social Security Income, and unemployment and workers' compensation benefits. Income **does not** include public assistance, Supplemental Security Income (SSI), child support or foster care payments made to you, profits from the sale of your residence, and account withdrawals or capital gains.

Applicant's current monthly gross income $_____

Spouse's current monthly gross income $_____

TOTAL $_____

Note: Sole proprietors may deduct their documented monthly business expenses in calculating monthly income.

Section F: Household Members

The household income limitation depends on the number of household members that you have. Household members include yourself, your spouse (if residing in the household), and dependent children. For each person listed, please indicate whether that person is applying for coverage. Sole proprietors may include a domestic partner, if they want coverage for the domestic partner under the policy. Fill in the name of the primary care physician chosen by each person to be covered, if known.

Applicant's Name (First, MI, Last)	**DOB**	**Applying for Coverage?** ☐ Yes ☐ No	**Social Security Number**
	Name of Primary Care Physician (If Known): Physician		
Spouse's or Domestic Partner's Name (First, MI, Last	**DOB**	**Applying for Coverage?** ☐ Yes ☑ No	**Social Security Number**
	Name of Primary Care Physician (If Known):		
Child's Name (First, MI, Last)	**DOB**	**Applying for Coverage?** ☑ Yes ☐ No	**Social Security Number**
	Name of Primary Care Physician (If Known):		
Child's Name (First, MI, Last)	**DOB**	**Applying for Coverage?** ☐ Yes ☐ No	**Social Security Number**
	Name of Primary Care Physician (If Known):		
Child's Name (First, MI, Last)	**DOB**	**Applying for Coverage?** ☐ Yes ☐ No	**Social Security Number**
	Name of Primary Care Physician (If Known):		
Child's Name (First, MI, Last)	**DOB**	**Applying for Coverage?** ☐ Yes ☐ No	**Social Security Number**
	Name of Primary Care Physician (If Known):		

Pregnant women count as two people for determining household size. Are any of the household members listed above pregnant?

☐ No ☐ Yes (Name _____)

Are any of the household members eligible for Medicare? Medicare is federal health insurance for people of all incomes. It is usually for people age 65 and older, and people who are disabled.

☐ No ☐ Yes (Name _____)

Section G: Documentation

You must attach documentation of NYS residence, employment within the past 12 months for you or your spouse, and your household income. Documentation should match your statements in earlier sections of the application. You must include documentation that shows your entire current monthly income, such as pay stubs for an entire month. Note that one document can fulfill more than one category. Please check the boxes below that show which types of documentation you are submitting.

NYS Residence (should match Section A)	Employment (should match Section C)	Household Income (should match Section E)
❑ NYS driver license	❑ Pay stubs	❑ Pay stubs
❑ Utility bill (gas, electric, cable, etc.) or postmarked mail with address	❑ Letter from employer	❑ Award letters/benefit checks
❑ Letter/lease/rent receipt from landlord	❑ Documentation sufficient to demonstrate self-employment	❑ Business records
❑ Property tax records or mortgage statement	❑ Other (explain): _____	❑ Letter from employer
❑ Other (explain):		❑ Other (explain): _____

Section H: Certification

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this certification are true to the best of my knowledge. I further certify that I am ineligible for health insurance provided by my employer and all individuals to be covered are ineligible for Medicare.

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant's Signature _____ Date _____

If a broker assisted you with completing this application, please include:

Broker's Name	License #	Company
Vista Health Solutions	LB-1033148	Vista Health Solutions

Address	Phone	E-mail
31 Park Ave. Suffern, NY, 10901	845-753-2320	info@nyhealthinsurer.com

Important Information about Pre-existing Conditions

A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months. Your Healthy NY policy will exclude coverage for that condition for up to 12 months. Pregnancy is a pre-existing condition in individual contracts, and coverage may be excluded for up to 10 months. Pregnancy is not a pre-existing condition for sole proprietors. This period may be reduced or eliminated if you are transferring from other health insurance coverage, which terminated no more than 63 days prior to the date that you submit your Healthy NY application. There are no pre-existing condition exclusions for anyone under 19. Please review your Healthy NY health insurance policy or contact your HMO for a full explanation of what is considered a pre-existing condition and how this restriction may affect you.

The 12-month exclusion period mentioned above is shorter if you have been determined to be eligible under the Federal Trade Adjustment Act of 2002. Please notify your HMO.

Detach and send your completed application directly to the HMO or participating insurer that you choose. For a list of HMOs and participating insurers and their addresses and rates, go to www.HealthyNY.com and select the link "HMOs and Rates by County."

Dear EmblemHealth

Be advised that I no longer receive the wages listed on my most recent tax form pertaining to the w2 enclosed.

Please contact me at the address listed above if you need any additional information

Thank you

X _____
Signature

_____
Print Name

owner _____
Title

Attn GHI:

(the "Group") hereby designates the broker with broker code 599F listed as the broker/consultant(s) of record (the "BOR") for the Group. Further, the Group hereby authorizes GHI & GHI HMO, to send all quotes, policies and notices to the BOR. The Group hereby acknowledges and agrees that notice to the BOR is notice to the Group.

This BOR designation shall remain in effect until it is expressly terminated by the Group in writing.

BrokerName,	Address	SSN	Commission
Vista Health Solutions Inc (599F)	31 Park Ave., Suffern NY 10901	204850104	100%

_____
Signature

_____
Print Name

_____
Title

_____
Date

Open Enrollment Form

High Deductible Health Plan Option for Individuals

How the High Deductible Health Plan Works
With a high deductible health plan (HDHP), you pay for most health care expenses up to a certain amount before the insurance policy begins to cover them. The standard deductible is $1,150 for individuals and $2,300 for families (more than one person). Because the plan carries a high deductible, the premium is lower. Check with your health plan to see if other deductible amounts are available.

You can access preventive services for cervical cytology screening, mammography screening, prostate cancer screening, periodic adult physical examinations, adult immunizations, routine prenatal care and well-child visits without having met the deductible. However, you will have a co-payment for these services. Co-payments do not apply towards the deductible.

Only benefits included in the Healthy NY benefit package count towards the deductible. You should ask your health plan about the cost of healthcare services before they are performed. With a family plan, any family member or combination of family members included in the health plan must meet the entire family deductible in order for coverage to begin. Once you meet the deductible, you are still responsible for co-payments, including $500 for inpatient hospitalization.

Out-of-pocket expenses are capped at $5,250 for individuals and $10,500 for families. This includes deductibles and co-payments.

High Deductible Health Plans and Health Savings Accounts
If you choose the HDHP, then you certify that you will set up a health savings account (HSA). An HSA is a savings account used to pay for medical expenses such as deductibles, co-payments and over-the-counter medication. You can contribute up to the deductible amount ($1,150 for individuals and $2,300 for families) into the account each year. However, the amount that you can contribute to the HSA is pro-rated if coverage begins after January 1. You can put money into the account in one lump sum or at any frequency that is convenient for you. It is very important to save all receipts if you have an HSA.

HSAs have several tax advantages:

- The money that you put into the HSA is tax-deductible.
- The money in the HSA can earn interest tax-free.
- As long as you use the money in the HSA for qualified medical expenses, then you are never taxed on it.

Visit the HSA Insider at www.HSAInsider.com or the U.S. Department of the Treasury at www.treas.gov for more information on HSAs and which banks offer them.

Be sure that you understand the difference between an HDHP and a plan with no deductible before you choose a plan. Remember that with an HDHP, you are responsible for paying most expenses out-of-pocket or through your HSA before your policy begins to cover them. For more information, visit the Healthy NY web site at www.HealthyNY.com.

To choose the HDHP, fill out the following and sign your name. Send this form to your health plan. **If you do not want the high deductible option, then you do not need to fill out this form.**

First _____ Middle _____ Last _____

X _____ _____
Name Signature Date

For Small Businesses & Working Individuals
HEALTHY NY
www.HealthyNY.com

TRANSACTION FORM FOR GROUP ACCOUNTS

MEMBERSHIP / P.O. BOX 2820 • NEW YORK, NY 10116-2820

(Please read important information on back before completing this form)

INTERNAL USE ONLY

CONTROL NUMBER

I. SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	TELEPHONE NUMBERS HOME / WORK / FAX
HOME ADDRESS (Include Apartment Number)			SEX ☐ Male ☐ Female — MARITAL STATUS ☐ Single ☐ Married ☐ Other _____
CITY	STATE NY	ZIP CODE	EMPLOYMENT STATUS ☑ Employed ☐ Not-Employed ☐ Retired ☐ COBRA ☐ RETIREE/RDS - EFFECTIVE DATE _____ — PRIMARY LANGUAGE SPOKEN

II. ENROLLMENT INFORMATION

NAME LAST	NAME FIRST	NAME M.I.	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER	SEX	RELATION-SHIP	MAILING ADDRESS (If different from above)	EMAIL ADDRESS	FULL TIME STUDENT (√)	ADD (√)	DELETE (√)	RACE/ETHNICITY (CODES BELOW)
SUBSCRIBER						SELF			X	X	X	
SPOUSE									X			
DEPENDENT								31 Park Ave. Suffern, NY, 10901				
DEPENDENT								845-753-2320				
DEPENDENT						Vista Health Solu		info@nyhealthinsurer.com				

III. OTHER CARRIER INFORMATION

Do you or any of your dependents have other health care coverage? ☐ Yes Please complete this section ☒ No GO TO SECTION IV

NAME OF OTHER INSURANCE CARRIER	TYPE OF CONTRACT ☒ Group ☐ Individual	NAME OF POLICY HOLDER LAST NAME	FIRST NAME	M.I.
CARRIER'S ADDRESS	CITY	STATE	ZIP CODE	POLICY NUMBER / EFFECTIVE DATE

IV. DID YOU HAVE PRIOR HEALTH COVERAGE

☐ YES Please provide a 12-month history of all coverage in this section ☐ NO GO TO SECTION V

	NAME AND ADDRESS OF INSURER	TELEPHONE NUMBER OF INSURER	NAME OF POLICYHOLDER	POLICY I.D. NUMBER	EFFECTIVE DATE OF CURRENT OR PRIOR POLICY	TERMINATION DATE OF CURRENT OR PRIOR POLICY
HOSPITAL						
MEDICAL						

V. EMPLOYER INFORMATION

GHI CERTIFICATE NUMBER OR EMPLOYEE SOCIAL SECURITY NUMBER	DATE OF HIRE	EMPLOYEE WAITING PERIOD
		☐ YES NUMBER OF WAITING PERIOD DAYS _____ ☐ NOT APPLICABLE NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____

Check one: ☐ New Enrollment ☐ Reinstatement ☐ Termination

STATUS CHANGE: ☐ Add Dependent ☐ Remove Dependent ☐ Address Change ☐ Name Change Reason for Change: _____

TRANSFER: ☐ To Another Carrier ☐ GHI Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? ☐ Yes ☐ No

VI. SUBSCRIBER AUTHORIZATION

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim concerning any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

X _____ Subscriber Signature _____ Date

GROUP AUTHORIZATION

X _____ Authorized Signature _____ Date _____ Phone Number

VII. GROUP NAME AND ADDRESS

EFFECTIVE DATE OF TRANSACTION

MEDICAL

HOSPITAL

DENTAL

GHI GROUP NUMBER

MEDICAL

HOSPITAL

DENTAL

RACE/ETHNICITY CODES: (Optional) A = ASIAN I = NATIVE AMERICAN OR ALASKAN NATIVE B = BLACK OR AFRICAN AMERICAN P = NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER C = CAUCASIAN O = OTHER H = HISPANIC OR LATINO

SEE INFORMATION/EXPLANATION ON REVERSE SIDE

FORM# 6204K 25M 7/07

LETTER of CERTIFICATION

EmblemHealth Introduces Standard Letter of Certification for Group Submissions

Effective April 1, 2003, all group submissions requiring a CPA/Attorney letter must now use a Standard Letter of Certification. This letter of certification will now be the only acceptable form of CPA/Attorney documentation.

This form is used in the event that sufficient tax documents are not available and cannot be submitted for re-qualification or in the event that the business status has changed (i.e. DBA or Name Change) and has no documentation to reflect that change.

PLEASE NOTE THAT ALL NEW GROUP OF ONE SUBMISSIONS WILL NOW REQUIRE THIS STANDARD LETTER OF CERTIFICATION.

Please check or respond where appropriate (type or print):

I am a duly licensed:

❒ A Certified Public Account (CPA), or
❒ An Attorney,

Name: _____
Firm Name: _____
Firm Address:_____
Telephone Number:_____
State of Licensure:_____

This letter of attestation is being provided on behalf or the following business entity:

Group's Name: _____
Group's Address:_____
Group's Telephone Number: _____Groups TIN:_____
Group Officer's Name (from whom you received the written documentation reviewed in connection with this letter of attestation):_____

The principal place of business for this group is in New York and this business is a:
(Check One Box)

❒ Sole Proprietorship, and the proprietor works a minimum of 20 hours per week.
❒ Partnership
❒ Corporation
❒ Limited Liability Company (LLC)
❒ Trust (attach supporting documentation)
❒ Other Type of Business Entity (explain) _____

(please attach copies of supporting documentation.)

Check Applicable Box(es)

❒ The following new employee _____ began working for this company on _____, and is working full-time (20 hours or more per week), and will be shown on future tax documents which can be reviewed at a later date.

❒ This group is a new business, which started on _____ and will be filing tax documents, which can be reviewed at a future date.

I hereby certify that the information I have stated above is true based on my review of books, records or other written documentation provided to me by the group and that the materials I have attached to this letter in support of this certification are true and accurate copies of records of the group. This certification forms part of the group's application for insurance. New York Insurance Law: An individual who provides false or misleading statements of material facts, or conceals material information in order to obtain insurance, commits a fraudulent insurance act, which is a crime.

Signature:_____ **Print Name & Title**:_____

Date: _____

Healthy New York Plan Design and Benefits

Plan Features	HMO Plan In-Network (Referred Care)	HMO/High-Deductible Health Plan (HDHP)
Deductible	N/A	$1,200 individual/$2,400 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	Deductible/$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	No copayment — 1 visit every 36 months	No deductible or copayment — 1 visit every 36 months
Routine Prostate Cancer Screening	No copayment	No deductible or copayment
Well-Baby and Well-Child Care; Immunizations; Physical Exam	No copayment	No deductible or copayment
Routine GYN Care	No 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	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 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	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	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	Deductible/$50 copayment
Ambulance	Not covered	Not covered
Outpatient Surgery (Facility)*	$75 facility copayment	Deductible/$75 facility copayment
Hospitalization (Facility)*	$500 facility copayment per continuous confinement	Deductible/$500 facility copayment per continuous confinement
Skilled Nursing Facility Care (in lieu of hospitalization for medically necessary covered benefits)	Not covered	Not covered

Plan Features	HMO Plan In-Network (Referred Care)	HMO/High-Deductible Health Plan (HDHP)
Maternity		
OB Visits	$10 copayment per visit for prenatal care $10 copayment for postnatal visit	No deductible/$10 copayment per visit for prenatal care Deductible/$10 copayment for postnatal visit
Hospital (Includes Newborn Services)*	$500 facility copayment per continuous confinement. 20% or $200 copayment, whichever is less	Deductible/$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	Not covered
Substance Abuse Detoxification		
Inpatient Detoxification	Not covered	Not covered
Outpatient Detoxification	Not covered	Not covered
Substance Abuse Rehabilitation		
Inpatient Rehabilitation	Not covered	Not covered
Outpatient Rehabilitation	Not covered	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 Deductible/$20 copayment per each item of equipment Deductible/$20 copayment per 34-day supply of insulin, hypoglycemics and supplies
Pharmacy THIS AREA WOULD ONLY APPLY FOR HNY HMO 2 and HDHP 2 plans		
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:** 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; Deductible/$40 copayment per brand-name drug per 90-day supply plus difference in cost between brand-name and its generic equivalent	**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 — 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.