Healthfirst PHSP, Inc.

Rate Manual Pursuant to New York Insurance Law Section 4308(c)

Off-Exchange Individual HMO Rates and Forms Submission

Effective January 1, 2014

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SECTION I –

Off-Exchange Individual HMO Standard Plan Rates

Section I.A – Rate Pages – With Pediatric Dental

HEALTHFIRST PHSP, INC.
OFF-EXCHANGE INDIVIDUAL HMO STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2014
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, & NASSAU COUNTIES

PROPOSED HMO PREMIUM RATES – STANDARD PLANS (WITH PEDIATRIC DENTAL)

PLAN NAME	Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$610.49	$515.21	$440.75	$376.29
Single + spouse	$1,220.97	$1,030.41	$881.50	$752.58
Single + child(ren)	$1,037.83	$875.85	$749.27	$639.69
Single + spouse + child(ren)	$1,739.89	$1,468.33	$1,256.13	$1,072.42

Form Numbers of policies to which these rates apply:

Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
HF-STDIND-14-OFF	HF-STDIND-14-OFF	HF-STDIND-14-OFF	HF-STDIND-14-OFF
HF-PSOB-14-OFF	HF-GSOB-14	HF-SSOB-14	HF-BSOB-14

With Dependent to Age 29 Rider (i.e., rates inclusive of the Age 29 rider)

PLAN NAME	Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$616.59	$520.36	$445.16	$380.05
Single + spouse	$1,233.18	$1,040.71	$890.31	$760.10
Single + child(ren)	$1,048.21	$884.61	$756.77	$646.09
Single + spouse + child(ren)	$1,757.29	$1,483.02	$1,268.69	$1,083.15

Form Numbers of policies to which these rates apply:

Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
HF-STDIND-14-OFF	HF-STDIND-14-OFF	HF-STDIND-14-OFF	HF-STDIND-14-OFF
HF-PSOB-14-OFF	HF-GSOB-14	HF-SSOB-14	HF-BSOB-14
HF-A29R-OFF	HF-A29R-OFF	HF-A29R-OFF	HF-A29R-OFF

HEALTHFIRST PHSP, INC.
OFF-EXCHANGE INDIVIDUAL HMO STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2014
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, & NASSAU COUNTIES

(continued from section on last page)

Child-only

PLAN NAME	Healthfirst HMO A Child Only	Healthfirst HMO B Child Only	Healthfirst HMO C Child Only	Healthfirst HMO D Child Only
METAL LEVEL	Platinum	Gold	Silver	Bronze
One Child	$251.52	$212.26	$181.59	$155.03
Two Children	$503.04	$424.53	$363.18	$310.06
Three or More Children	$754.56	$636.79	$544.77	$465.09

Form Numbers of policies to which these rates apply:

Healthfirst HMO A Child-Only	Healthfirst HMO B Child-Only	Healthfirst HMO C Child-Only	Healthfirst HMO D Child-Only
HF-STDCO-14-OFF	HF-STDCO-14-OFF	HF-STDCO-14-OFF	HF-STDCO-14-OFF
HF-PSOB-14-OFF	HF-GSOB-14	HF-SSOB-14	HF-BSOB-14

Section I.B – Rate Pages – Without Pediatric Dental

HEALTHFIRST PHSP, INC.
OFF-EXCHANGE INDIVIDUAL HMO STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2014
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, & NASSAU COUNTIES

PROPOSED HMO PREMIUM RATES – STANDARD PLANS (WITHOUT PEDIATRIC DENTAL)

PLAN NAME	Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$609.45	$514.33	$440.00	$375.65
Single + spouse	$1,218.89	$1,028.66	$880.00	$751.30
Single + child(ren)	$1,036.06	$874.36	$748.00	$638.61
Single + spouse + child(ren)	$1,736.92	$1,465.83	$1,254.00	$1,070.60

Form Numbers of policies to which these rates apply:

Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
HF-STDIND-14-OFF	HF-STDIND-14-OFF	HF-STDIND-14-OFF	HF-STDIND-14-OFF
HF-PSOB-14-OFF	HF-GSOB-14	HF-SSOB-14	HF-BSOB-14

With Dependent to Age 29 Rider (i.e., rates inclusive of the Age 29 rider)

PLAN NAME	Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$615.54	$519.47	$440.40	$379.41
Single + spouse	$1,231.08	$1,038.94	$888.80	$758.81
Single + child(ren)	$1,046.42	$883.10	$755.48	$644.99
Single + spouse + child(ren)	$1,754.29	$1,480.49	$1,266.54	$1,081.31

Form Numbers of policies to which these rates apply:

Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
HF-STDIND-14-OFF	HF-STDIND-14-OFF	HF-STDIND-14-OFF	HF-STDIND-14-OFF
HF-PSOB-14-OFF	HF-GSOB-14	HF-SSOB-14	HF-BSOB-14
HF-A29R-OFF	HF-A29R-OFF	HF-A29R-OFF	HF-A29R-OFF

HEALTHFIRST PHSP, INC.
OFF-EXCHANGE INDIVIDUAL HMO STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2014
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, & NASSAU COUNTIES

(continued from section on last page)

Child-only

PLAN NAME	Healthfirst HMO A Child Only	Healthfirst HMO B Child Only	Healthfirst HMO C Child Only	Healthfirst HMO D Child Only
METAL LEVEL	Platinum	Gold	Silver	Bronze
One Child	$251.09	$211.90	$181.28	$154.77
Two Children	$502.18	$423.81	$362.56	$309.54
Three or More Children	$753.27	$635.71	$543.84	$464.30

Form Numbers of policies to which these rates apply:

Healthfirst HMO A Child-Only	Healthfirst HMO B Child-Only	Healthfirst HMO C Child-Only	Healthfirst HMO D Child-Only
HF-STDCO-14-OFF	HF-STDCO-14-OFF	HF-STDCO-14-OFF	HF-STDCO-14-OFF
HF-PSOB-14-OFF	HF-GSOB-14	HF-SSOB-14	HF-BSOB-14

Section I.C – Description of Rating Classes, Factors, & Premium Discounts

Healthfirst PHSP, Inc.'s rates have been developed in accordance with New York State's community rating laws. Premiums for every member covered under the same policy are the same regardless of age, sex, health status or occupation. The risk for on-Exchange and off-Exchange plans, in accordance with the Patient Protection and Affordable Care Act of 2010 and its associated regulations, is pooled into a single risk pool. As illustrated below, these rates within the community rated pool vary based on only several factors: geographic region, dependent age limit, the inclusion of a pediatric dental benefit, and family/census tier.

Census Tiers	Cost Factor
Single	**1.000**
Single + Spouse	**2.000**
Single + Child(ren)	**1.700**
Single + Spouse + Child(ren)	**2.850**
Child Only	**0.412**

Pediatric Dental Benefit	Cost Factor
Included	**1.000**
Not Included	**0.998**

Rating Region	Counties Included	Area Factor
New York City	Bronx, Kings, New York, Queens, Richmond	1.000
Long Island	Nassau	1.000

Dependent Age Limit	Cost Factor
26	**1.000**
29	**1.010**

Section I.D – Rate Calculation Examples

The entirety of premium rates for Healthfirst PHSP, Inc.'s on-Exchange Individual plans is listed above in the rate tables in sections I.A and I.B (pages 5-8 of this rate manual). An example of how to look up a particular premium rate is below.

EXAMPLE:

Consumer Profile: A single individual (subscriber) with two children living in Nassau County choosing the Gold Standard Plan with pediatric dental benefits, and not choosing the Age 29 Rider.

Rate Look-Up Solution: There are no differences in premium rates for the two different rating regions included in this product (Regions 4 and 8), therefore the consumer is advised to proceed to page 5 and refer to the first table under the heading "Proposed HMO Premium Rates – Standard Plans (With Pediatric Dental)." Next, the consumer would refer to the column labeled, "Healthfirst HMO B" and cross-reference the row labeled, "Single + Child(ren)." The rate for this plan is $875.85 per month.

Section I.E – Expected Loss Ratios

For the plans listed in this rate manual, the projected loss ratio using the Federally prescribed medical loss ratio (MLR) methodology is 86.5%. The expected loss ratio under New York State's MLR methodology is 83.8%. These projected loss ratios are greater than the Federally prescribed 80% minimum for Individual products, as well as the 82% minimum prescribed by New York State for Individual products.

SECTION II –

Description of Benefits, Types of Coverage, Limitations, Exclusions, Issue Limits, & Renewal Conditions

***Please note**: each benefit grid applies to the plan name listed, as well as its corresponding child-only standard plan (listed in parenthesis). In addition, each plan includes two benefit grids, one inclusive of pediatric dental benefits, and another without pediatric dental benefits.

Section II.A – Platinum Standard Plan Benefit Description

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits		
Deductible	**Individual - $0; Family - $0**	
Max. Out of Pocket Limit	**Individual - $2,000; Family - $4,000**	
OFFICE VISITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$15 Copayment	No limit
Specialist Office Visits (or Home Visits)	$35 Copayment	No limit
PREVENTIVE CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Well Child Visits and Immunizations	Covered in full/0% cost-sharing	No limit
Adult Annual Physical Examinations	Covered in full/0% cost-sharing	No limit
Adult Immunizations	Covered in full/0% cost-sharing	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full/0% cost-sharing	No limit
Mammography Screenings	Covered in full/0% cost-sharing	No limit
Sterilization Procedures for Women	• Covered in full • $35 Copayment	No limit
Vasectomy	• Covered in full • $35 Copayment	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	• Covered in full • $35 Copayment	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.
Family Planning Services for Women	Covered in full/0% cost-sharing	No limit
All other preventive services required by USPSTF and HRSA under the Affordable Care Act.	Covered in full/0% cost-sharing	No limit
EMERGENCY CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$100 Copayment	No limit
Non-Emergency Ambulance Services	$100 Copayment	No limit
Emergency Department	• $100 Copayment • Copayment waived if Hospital admission	No limit
Urgent Care Center	$55 Copayment	No limit
PROFESSIONAL SERVICES AND OUTPATIENT CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology	$35 Copayment	No limit

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits		
Facility or Office Setting • Performed as Outpatient Hospital Services	$35 Copayment	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Ambulatory Surgical Center Facility Fee	$100 Copayment	No limit
Anesthesia Services (all settings)	Covered in full	No limit
Autologous Blood Banking	10% Coinsurance	No limit
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$15 Copayment $15 Copayment $500 Copayment per admission	No limit
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$15 Copayment $15 Copayment $15 Copayment	No limit
Chiropractic Services	$35 Copayment	No limit
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$15 Copayment $35 Copayment $35 Copayment	No limit
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	$15 Copayment $15 Copayment $15 Copayment	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment	60 visits per condition, per lifetime combined therapies
Home Health Care	$15 Copayment	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic	• Member must be between ages of 21 and 44 • Advanced infertility not covered

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits		
	Procedures)	
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $15 Copayment $15 Copayment $15 Copayment $15 Copayment	No limit Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full/0% cost-sharing	No limit
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $35 Copayment $35 Copayment	No limit
Maternity & Newborn Care • Prenatal & Postnatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	 Covered in full/0% cost-sharing $500 Copayment per admission $100 Copayment Covered in full/0% cost-sharing	 No limit 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early No limit Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	$100 Copayment	No limit
Preadmission Testing	Covered in full/0% cost-sharing	No limit
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $35 Copayment $35 Copayment	No limit
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	 $15 Copayment	No limit

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits		
• Performed as Outpatient Hospital Service	$15 Copayment	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$35 Copayment	• One second surgical opinion on the need for surgery • For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 $100 Copayment $100 Copayment $100 Copayment $35 Copayment	• No limit • Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. • Oral Surgery due to injury is limited to sound and natural teeth only.
Elective Termination of Pregnancy	$100 Copayment	• 1 Treatment per Year • Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT & DEVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$15 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$15 Copayment	Limited to dedicated devices
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 $15 Copayment $15 Copayment	No limit
Durable Medical Equipment & Braces	10% Coinsurance	Coverage for standard equipment only.
External Hearing Aids	10% Coinsurance	• Single Purchase Once Every 3 Years

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits		
Cochlear Implants	10% Coinsurance	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient	$500 Copayment per admission $15 Copayment	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	10% Coinsurance	
Prosthetic Devices • External • Internal	10% Coinsurance 10% Coinsurance	One prosthetic device, per limb, per lifetime No limit
INPATIENT SERVICES & FACILITIES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	$500 Copayment per admission	No limit
Observation Stay	$100 Copayment	No limit
Bariatric Surgery	$100 Copayment per admission	No limit
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	$500 Copayment per admission	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	$500 Copayment per admission	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$500 Copayment per admission	No limit
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$15 Copayment	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$500 Copayment per admission	No limit
Outpatient Substance Use Services	$15 Copayment	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Enteral Formula	Use appropriate prescription drug tier cost-sharing	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
Retail Pharmacy		
30 Day Supply Tier 1	$10 Copayment	No limit

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits		
Tier 2 Tier 3	$30 Copayment $60 Copayment	
Up to a 90 Day Supply For Maintenance Drugs Tier 1 Tier 2 Tier 3	 $25 Copayment $75 Copayment $150 Copayment	No limit
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $25 Copayment $75 Copayment $150 Copayment	No limit
WELLNESS BENEFITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Gym Reimbursement	Not Applicable	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC DENTAL &VISION CARE		
	In-Network Cost-Sharing	**Limits**
Pediatric Dental Care • Preventive/Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 $15 Copayment $15 Copayment $15 Copayment	 One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	 $15 Copayment 10% Coinsurance 10% Coinsurance	 One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period Covered when medically necessary

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits, without Pediatric Dental		
Deductible	**Individual - $0; Family - $0**	
Max. Out of Pocket Limit	**Individual - $2,000; Family - $4,000**	
OFFICE VISITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$15 Copayment	No limit
Specialist Office Visits (or Home Visits)	$35 Copayment	No limit
PREVENTIVE CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Well Child Visits and Immunizations	Covered in full/0% cost-sharing	No limit
Adult Annual Physical Examinations	Covered in full/0% cost-sharing	No limit
Adult Immunizations	Covered in full/0% cost-sharing	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full/0% cost-sharing	No limit
Mammography Screenings	Covered in full/0% cost-sharing	No limit
Sterilization Procedures for Women	• Covered in full • $35 Copayment	No limit
Vasectomy	• Covered in full • $35 Copayment	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	• Covered in full • $35 Copayment	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.
Family Planning Services for Women	Covered in full/0% cost-sharing	No limit
All other preventive services required by USPSTF and HRSA under the Affordable Care Act.	Covered in full/0% cost-sharing	No limit
EMERGENCY CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$100 Copayment	No limit
Non-Emergency Ambulance Services	$100 Copayment	No limit
Emergency Department	• $100 Copayment • Copayment waived if Hospital admission	No limit
Urgent Care Center	$55 Copayment	No limit
PROFESSIONAL SERVICES AND OUTPATIENT CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	$35 Copayment	No limit

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits, without Pediatric Dental		
• Performed as Outpatient Hospital Services	$35 Copayment	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Ambulatory Surgical Center Facility Fee	$100 Copayment	No limit
Anesthesia Services (all settings)	Covered in full	No limit
Autologous Blood Banking	10% Coinsurance	No limit
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $15 Copayment $15 Copayment $500 Copayment per admission	No limit
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $15 Copayment $15 Copayment	No limit
Chiropractic Services	$35 Copayment	No limit
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $35 Copayment $35 Copayment	No limit
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 $15 Copayment $15 Copayment $15 Copayment	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment	60 visits per condition, per lifetime combined therapies
Home Health Care	$15 Copayment	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic	• Member must be between ages of 21 and 44 • Advanced infertility not covered

Healthfirst HMO A (& Healthfirst HMO A Child-Only) Standard Benefits, without Pediatric Dental		
	Procedures)	
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $15 Copayment $15 Copayment $15 Copayment $15 Copayment	No limit Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full/0% cost-sharing	No limit
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $35 Copayment $35 Copayment	No limit
Maternity & Newborn Care • Prenatal & Postnatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	 Covered in full/0% cost-sharing $500 Copayment per admission $100 Copayment Covered in full/0% cost-sharing	 No limit 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early No limit Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	$100 Copayment	No limit
Preadmission Testing	Covered in full/0% cost-sharing	No limit
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $35 Copayment $35 Copayment	No limit
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	 $15 Copayment	No limit

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits, without Pediatric Dental		
• Performed as Outpatient Hospital Service	$15 Copayment	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$35 Copayment	• One second surgical opinion on the need for surgery • For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 $100 Copayment $100 Copayment $100 Copayment $35 Copayment	• No limit • Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. • Oral Surgery due to injury is limited to sound and natural teeth only.
Elective Termination of Pregnancy	$100 Copayment	• 1 Treatment per Year • Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT & DEVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$15 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$15 Copayment	Limited to dedicated devices
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 $15 Copayment $15 Copayment	No limit
Durable Medical Equipment & Braces	10% Coinsurance	Coverage for standard equipment only.
External Hearing Aids	10% Coinsurance	• Single Purchase Once Every 3 Years

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits, without Pediatric Dental		
Cochlear Implants	10% Coinsurance	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient	$500 Copayment per admission $15 Copayment	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	10% Coinsurance	
Prosthetic Devices • External • Internal	10% Coinsurance 10% Coinsurance	One prosthetic device, per limb, per lifetime No limit
INPATIENT SERVICES & FACILITIES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	$500 Copayment per admission	No limit
Observation Stay	$100 Copayment	No limit
Bariatric Surgery	$100 Copayment per admission	No limit
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	$500 Copayment per admission	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	$500 Copayment per admission	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$500 Copayment per admission	No limit
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$15 Copayment	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$500 Copayment per admission	No limit
Outpatient Substance Use Services	$15 Copayment	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Enteral Formula	Use appropriate prescription drug tier cost-sharing	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
Retail Pharmacy		
30 Day Supply Tier 1	$10 Copayment	No limit

Healthfirst HMO A (& Healthfirst HMO A Child-Only)		
Standard Benefits, without Pediatric Dental		
Tier 2 Tier 3	$30 Copayment $60 Copayment	
Up to a 90 Day Supply For Maintenance Drugs Tier 1 Tier 2 Tier 3	 $25 Copayment $75 Copayment $150 Copayment	No limit
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $25 Copayment $75 Copayment $150 Copayment	No limit
WELLNESS BENEFITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Gym Reimbursement	Not Applicable	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC VISION CARE		
	In-Network Cost-Sharing	**Limits**
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	 $15 Copayment 10% Coinsurance 10% Coinsurance	 One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period Covered when medically necessary

Section II.B – Gold Standard Plan Benefit Description

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits		
Deductible	**Individual - $600; Family - $1,200**	
Max. Out of Pocket Limit	**Individual - $4,000; Family - $8,000**	
OFFICE VISITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$25 Copayment	No limit
Specialist Office Visits (or Home Visits)	$40 Copayment	No limit
PREVENTIVE CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Well Child Visits and Immunizations	Covered in full/0% cost-sharing	No limit
Adult Annual Physical Examinations	Covered in full/0% cost-sharing	No limit
Adult Immunizations	Covered in full/0% cost-sharing	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full/0% cost-sharing	No limit
Mammography Screenings	Covered in full/0% cost-sharing	No limit
Sterilization Procedures for Women	• Covered in full • $40 Copayment	No limit
Vasectomy	• Covered in full • $40 Copayment	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	• Covered in full • $40 Copayment	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.
Family Planning Services for Women	Covered in full/0% cost-sharing	No limit
All other preventive services required by USPSTF and HRSA under the Affordable Care Act.	Covered in full/0% cost-sharing	No limit
EMERGENCY CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$150 Copayment	No limit
Non-Emergency Ambulance Services	$150 Copayment	No limit
Emergency Department	• $150 Copayment • Copayment waived if Hospital admission	No limit
Urgent Care Center	$60 Copayment	No limit
PROFESSIONAL SERVICES AND OUTPATIENT CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology	$40 Copayment	No limit

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits		
Facility or Office Setting • Performed as Outpatient Hospital Services	$40 Copayment	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Ambulatory Surgical Center Facility Fee	$100 Copayment	No limit
Anesthesia Services (all settings)	Covered in full/0% cost-sharing	No limit
Autologous Blood Banking	20% Coinsurance	No limit
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$25 Copayment $25 Copayment $1,000 Copayment per admission	No limit
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$25 Copayment $25 Copayment $25 Copayment	No limit
Chiropractic Services	$40 Copayment	No limit
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$25 Copayment $40 Copayment $40 Copayment	No limit
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	$25 Copayment $25 Copayment $25 Copayment	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment	60 visits per condition, per lifetime combined therapies
Home Health Care	$25 Copayment	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic	• Member must be between ages of 21 and 44 • Advanced infertility not covered

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits		
	Procedures)	
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $25 Copayment $25 Copayment $25 Copayment $25 Copayment	No limit Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full/0% cost-sharing	No limit
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $40 Copayment $40 Copayment	No limit
Maternity & Newborn Care • Prenatal & Postnatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	 Covered in full/0% cost-sharing $1,000 Copayment per admission $100 Copayment Covered in full/0% cost-sharing	 No limit 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early No limit Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	$100 Copayment	No limit
Preadmission Testing	Covered in full/0% cost-sharing	No limit
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $40 Copayment $40 Copayment	No limit
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	 $25 Copayment $25 Copayment	No limit

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits		
• Performed as Outpatient Hospital Service		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$40 Copayment	• One second surgical opinion on the need for surgery • For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 $100 Copayment $100 Copayment $100 Copayment $40 Copayment	• No limit • Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. • Oral Surgery due to injury is limited to sound and natural teeth only.
Elective Termination of Pregnancy	$100 Copayment	• 1 Treatment per Year • Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT & DEVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$25 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$25 Copayment	Limited to dedicated devices
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 $25 Copayment $25 Copayment	No limit
Durable Medical Equipment & Braces	20% Coinsurance	Coverage for standard equipment only.
External Hearing Aids	20% Coinsurance	• Single Purchase Once Every 3 Years
Cochlear Implants	20% Coinsurance	One Per Ear Per Time Covered

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits		
Hospice Care • Inpatient • Outpatient	$1000 Copayment per admission $25 Copayment	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance	
Prosthetic Devices • External • Internal	20% Coinsurance 20% Coinsurance	One prosthetic device, per limb, per lifetime No limit
INPATIENT SERVICES & FACILITIES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	$1000 Copayment per admission	No limit
Observation Stay	$150 Copayment	No limit
Bariatric Surgery	$100 Copayment per admission	No limit
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	$1000 Copayment per admission	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	$1000 Copayment per admission	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$1000 Copayment per admission	No limit
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$25 Copayment	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$1000 Copayment per admission	No limit
Outpatient Substance Use Services	$25 Copayment	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Enteral Formula	Use appropriate prescription drug tier cost-sharing	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
Retail Pharmacy		
30 Day Supply Tier 1	$10 Copayment	No limit

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits		
Tier 2 Tier 3	$35 Copayment $70 Copayment	
Up to a 90 Day Supply For Maintenance Drugs Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	No limit
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	No limit
WELLNESS BENEFITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Gym Reimbursement	Not Applicable	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC DENTAL &VISION CARE		
	In-Network Cost-Sharing	**Limits**
Pediatric Dental Care • Preventive/Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 $25 Copayment $25 Copayment $25 Copayment	 One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	 $25 Copayment 20% Coinsurance 20% Coinsurance	 One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period Covered when medically necessary

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits, without Pediatric Dental		
Deductible	**Individual - $600; Family - $1,200**	
Max. Out of Pocket Limit	**Individual - $4,000; Family - $8,000**	
OFFICE VISITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$25 Copayment	No limit
Specialist Office Visits (or Home Visits)	$40 Copayment	No limit
PREVENTIVE CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Well Child Visits and Immunizations	Covered in full/0% cost-sharing	No limit
Adult Annual Physical Examinations	Covered in full/0% cost-sharing	No limit
Adult Immunizations	Covered in full/0% cost-sharing	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full/0% cost-sharing	No limit
Mammography Screenings	Covered in full/0% cost-sharing	No limit
Sterilization Procedures for Women	• Covered in full • $40 Copayment	No limit
Vasectomy	• Covered in full • $40 Copayment	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	• Covered in full • $40 Copayment	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.
Family Planning Services for Women	Covered in full/0% cost-sharing	No limit
All other preventive services required by USPSTF and HRSA under the Affordable Care Act.	Covered in full/0% cost-sharing	No limit
EMERGENCY CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$150 Copayment	No limit
Non-Emergency Ambulance Services	$150 Copayment	No limit
Emergency Department	• $150 Copayment • Copayment waived if Hospital admission	No limit
Urgent Care Center	$60 Copayment	No limit
PROFESSIONAL SERVICES AND OUTPATIENT CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	$40 Copayment	No limit

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits, without Pediatric Dental		
• Performed as Outpatient Hospital Services	$40 Copayment	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Ambulatory Surgical Center Facility Fee	$100 Copayment	No limit
Anesthesia Services (all settings)	Covered in full/0% cost-sharing	No limit
Autologous Blood Banking	20% Coinsurance	No limit
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $25 Copayment $25 Copayment $1,000 Copayment per admission	No limit
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $25 Copayment $25 Copayment	No limit
Chiropractic Services	$40 Copayment	No limit
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $40 Copayment $40 Copayment	No limit
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 $25 Copayment $25 Copayment $25 Copayment	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment	60 visits per condition, per lifetime combined therapies
Home Health Care	$25 Copayment	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic	• Member must be between ages of 21 and 44 • Advanced infertility not covered

Healthfirst HMO B (& Healthfirst HMO B Child-Only) Standard Benefits, without Pediatric Dental		
	Procedures)	
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $25 Copayment $25 Copayment $25 Copayment $25 Copayment	No limit Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full/0% cost-sharing	No limit
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $40 Copayment $40 Copayment	No limit
Maternity & Newborn Care • Prenatal & Postnatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	 Covered in full/0% cost-sharing $1,000 Copayment per admission $100 Copayment Covered in full/0% cost-sharing	 No limit 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early No limit Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	$100 Copayment	No limit
Preadmission Testing	Covered in full/0% cost-sharing	No limit
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $40 Copayment $40 Copayment	No limit
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	 $25 Copayment $25 Copayment	No limit

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits, without Pediatric Dental		
• Performed as Outpatient Hospital Service		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$40 Copayment	• One second surgical opinion on the need for surgery • For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 $100 Copayment $100 Copayment $100 Copayment $40 Copayment	• No limit • Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. • Oral Surgery due to injury is limited to sound and natural teeth only.
Elective Termination of Pregnancy	$100 Copayment	• 1 Treatment per Year • Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT & DEVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$25 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$25 Copayment	Limited to dedicated devices
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 $25 Copayment $25 Copayment	No limit
Durable Medical Equipment & Braces	20% Coinsurance	Coverage for standard equipment only.
External Hearing Aids	20% Coinsurance	• Single Purchase Once Every 3 Years
Cochlear Implants	20% Coinsurance	One Per Ear Per Time Covered

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits, without Pediatric Dental		
Hospice Care • Inpatient • Outpatient	$1000 Copayment per admission $25 Copayment	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance	
Prosthetic Devices • External • Internal	20% Coinsurance 20% Coinsurance	One prosthetic device, per limb, per lifetime No limit
INPATIENT SERVICES & FACILITIES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	$1000 Copayment per admission	No limit
Observation Stay	$150 Copayment	No limit
Bariatric Surgery	$100 Copayment per admission	No limit
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	$1000 Copayment per admission	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	$1000 Copayment per admission	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$1000 Copayment per admission	No limit
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$25 Copayment	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$1000 Copayment per admission	No limit
Outpatient Substance Use Services	$25 Copayment	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Enteral Formula	Use appropriate prescription drug tier cost-sharing	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
Retail Pharmacy		
30 Day Supply Tier 1	$10 Copayment	No limit

Healthfirst HMO B (& Healthfirst HMO B Child-Only)		
Standard Benefits, without Pediatric Dental		
Tier 2 Tier 3	$35 Copayment $70 Copayment	
Up to a 90 Day Supply For Maintenance Drugs Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	No limit
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	No limit
WELLNESS BENEFITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Gym Reimbursement	Not Applicable	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC VISION CARE		
	In-Network Cost-Sharing	**Limits**
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	 $25 Copayment 20% Coinsurance 20% Coinsurance	 One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period Covered when medically necessary

Section II.C – Silver Standard Plan Benefit Description

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
Deductible	**Individual - $2,000; Family - $4,000**	
Max. Out of Pocket Limit	**Individual - $5,500; Family - $11,000**	
OFFICE VISITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$30 Copayment	No limit
Specialist Office Visits (or Home Visits)	$50 Copayment	No limit
PREVENTIVE CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Well Child Visits and Immunizations	Covered in full/0% cost-sharing	No limit
Adult Annual Physical Examinations	Covered in full/0% cost-sharing	No limit
Adult Immunizations	Covered in full/0% cost-sharing	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full/0% cost-sharing	No limit
Mammography Screenings	Covered in full/0% cost-sharing	No limit
Sterilization Procedures for Women	• Covered in full • $50 Copayment	No limit
Vasectomy	• Covered in full • $50 Copayment	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	• Covered in full • $50 Copayment	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.
Family Planning Services for Women	Covered in full/0% cost-sharing	No limit
All other preventive services required by USPSTF and HRSA under the Affordable Care Act.	Covered in full/0% cost-sharing	No limit
EMERGENCY CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$150 Copayment	No limit
Non-Emergency Ambulance Services	$150 Copayment	No limit
Emergency Department	• $150 Copayment • Copayment waived if Hospital admission	No limit
Urgent Care Center	$70 Copayment	No limit
PROFESSIONAL SERVICES AND OUTPATIENT CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	$50 Copayment	No limit

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
• Performed as Outpatient Hospital Services	$50 Copayment	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Ambulatory Surgical Center Facility Fee	$100 Copayment	No limit
Anesthesia Services (all settings)	Covered in full	No limit
Autologous Blood Banking	30% Coinsurance after deductible	No limit
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $30 Copayment $30 Copayment $1,500 Copayment per admission	No limit
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment $30 Copayment $30 Copayment	No limit
Chiropractic Services	$50 Copayment	No limit
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment $50 Copayment $50 Copayment	No limit
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 $30 Copayment $30 Copayment $30 Copayment	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &	• Member must be between ages of 21 and 44 • Advanced infertility not covered

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
	Diagnostic Procedures)	
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $30 Copayment $30 Copayment $30 Copayment $30 Copayment	No limit Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full/0% cost-sharing	No limit
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment $50 Copayment $50 Copayment	No limit
Maternity & Newborn Care • Prenatal & Postnatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	 Covered in full/0% cost-sharing $1,500 Copayment per admission $100 Copayment Covered in full/0% cost-sharing	 No limit 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early No limit Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	$100 Copayment	No limit
Preadmission Testing	Covered in full/0% cost-sharing	No limit
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment $50 Copayment $50 Copayment	No limit
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Service	 $30 Copayment $30 Copayment	No limit

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$50 Copayment	• One second surgical opinion on the need for surgery • For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 $100 Copayment $100 Copayment $100 Copayment $50 Copayment	• No limit • Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. • Oral Surgery due to injury is limited to sound and natural teeth only.
Elective Termination of Pregnancy	$100 Copayment	• 1 Treatment per Year • Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT & DEVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$30 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$30 Copayment	Limited to dedicated devices
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 $30 Copayment $30 Copayment	No limit
Durable Medical Equipment & Braces	30% Coinsurance	Coverage for standard equipment only.
External Hearing Aids	30% Coinsurance	Single Purchase Once Every 3 Years
Cochlear Implants	30% Coinsurance	One Per Ear Per Time Covered

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
Hospice Care • Inpatient • Outpatient	$1500 Copayment per admission $30 Copayment after deductible	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	30% Coinsurance	
Prosthetic Devices • External • Internal	30% Coinsurance 30% Coinsurance	One prosthetic device, per limb, per lifetime No limit
INPATIENT SERVICES & FACILITIES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	$1500 Copayment per admission	No limit
Observation Stay	$150 Copayment	No limit
Bariatric Surgery	$100 Copayment per admission	No limit
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	$1500 Copayment per admission	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	$1500 Copayment per admission	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$1500 Copayment per admission	No limit
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$30 Copayment	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$1500 Copayment per admission	No limit
Outpatient Substance Use Services	$30 Copayment	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Enteral Formula	Use appropriate prescription drug tier cost-sharing	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2	 $10 Copayment $35 Copayment	No limit

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
Tier 3	$70 Copayment	
Up to a 90 Day Supply For Maintenance Drugs Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	No limit
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	No limit
WELLNESS BENEFITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Gym Reimbursement	Not Applicable	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC DENTAL &VISION CARE		
	In-Network Cost-Sharing	**Limits**
Pediatric Dental Care • Preventive/Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 $30 Copayment $30 Copayment $30 Copayment	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	 $30 Copayment 30% Coinsurance 30% Coinsurance	 One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period Covered when medically necessary

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
Deductible	**Individual - $2,000; Family - $4,000**	
Max. Out of Pocket Limit	**Individual - $5,500; Family - $11,000**	
OFFICE VISITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$30 Copayment	No limit
Specialist Office Visits (or Home Visits)	$50 Copayment	No limit
PREVENTIVE CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Well Child Visits and Immunizations	Covered in full/0% cost-sharing	No limit
Adult Annual Physical Examinations	Covered in full/0% cost-sharing	No limit
Adult Immunizations	Covered in full/0% cost-sharing	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full/0% cost-sharing	No limit
Mammography Screenings	Covered in full/0% cost-sharing	No limit
Sterilization Procedures for Women	• Covered in full • $50 Copayment	No limit
Vasectomy	• Covered in full • $50 Copayment	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	• Covered in full • $50 Copayment	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.
Family Planning Services for Women	Covered in full/0% cost-sharing	No limit
All other preventive services required by USPSTF and HRSA under the Affordable Care Act.	Covered in full/0% cost-sharing	No limit
EMERGENCY CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$150 Copayment	No limit
Non-Emergency Ambulance Services	$150 Copayment	No limit
Emergency Department	• $150 Copayment • Copayment waived if Hospital admission	No limit
Urgent Care Center	$70 Copayment	No limit
PROFESSIONAL SERVICES AND OUTPATIENT CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	$50 Copayment $50 Copayment	No limit

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Ambulatory Surgical Center Facility Fee	$100 Copayment	No limit
Anesthesia Services (all settings)	Covered in full	No limit
Autologous Blood Banking	30% Coinsurance after deductible	No limit
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $30 Copayment $30 Copayment $1,500 Copayment per admission	No limit
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment $30 Copayment $30 Copayment	No limit
Chiropractic Services	$50 Copayment	No limit
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment $50 Copayment $50 Copayment	No limit
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 $30 Copayment $30 Copayment $30 Copayment	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		No limit

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
• Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	$30 Copayment $30 Copayment $30 Copayment $30 Copayment	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full/0% cost-sharing	No limit
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$30 Copayment $50 Copayment $50 Copayment	No limit
Maternity & Newborn Care • Prenatal & Postnatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered in full/0% cost-sharing $1,500 Copayment per admission $100 Copayment Covered in full/0% cost-sharing	No limit 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early No limit Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	$100 Copayment	No limit
Preadmission Testing	Covered in full/0% cost-sharing	No limit
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	$30 Copayment $50 Copayment $50 Copayment	No limit
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Service	$30 Copayment $30 Copayment	No limit
Rehabilitation Services (Physical Therapy, Occupational Therapy or	$30 Copayment	60 visits per condition, per lifetime combined therapies

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
Speech Therapy)		Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$50 Copayment	• One second surgical opinion on the need for surgery • For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 $100 Copayment $100 Copayment $100 Copayment $50 Copayment	• No limit • Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. • Oral Surgery due to injury is limited to sound and natural teeth only.
Elective Termination of Pregnancy	$100 Copayment	• 1 Treatment per Year • Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT & DEVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$30 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$30 Copayment	Limited to dedicated devices
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 $30 Copayment $30 Copayment	No limit
Durable Medical Equipment & Braces	30% Coinsurance	Coverage for standard equipment only.
External Hearing Aids	30% Coinsurance	Single Purchase Once Every 3 Years
Cochlear Implants	30% Coinsurance	One Per Ear Per Time Covered
Hospice Care • Inpatient	 $1500 Copayment per admission	 210 Days per Plan Year

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
• Outpatient	$30 Copayment after deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	30% Coinsurance	
Prosthetic Devices • External • Internal	 30% Coinsurance 30% Coinsurance	 One prosthetic device, per limb, per lifetime No limit
INPATIENT SERVICES & FACILITIES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	$1500 Copayment per admission	No limit
Observation Stay	$150 Copayment	No limit
Bariatric Surgery	$100 Copayment per admission	No limit
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	$1500 Copayment per admission	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	$1500 Copayment per admission	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$1500 Copayment per admission	No limit
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$30 Copayment	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$1500 Copayment per admission	No limit
Outpatient Substance Use Services	$30 Copayment	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Enteral Formula	Use appropriate prescription drug tier cost-sharing	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment $35 Copayment $70 Copayment	No limit
Up to a 90 Day Supply For Maintenance		No limit

Healthfirst HMO C (& Healthfirst HMO C Child-Only)		
Standard Benefits		
Drugs Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	No limit
WELLNESS BENEFITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Gym Reimbursement	Not Applicable	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC VISION CARE		
	In-Network Cost-Sharing	**Limits**
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	 $30 Copayment 30% Coinsurance 30% Coinsurance	 One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period Covered when medically necessary

Section II.D – Bronze Standard Plan Benefit Description

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits		
Deductible	**Individual - $3,000; Family - $6,000**	
Max. Out of Pocket Limit	**Individual - $6,350; Family - $12,700**	
OFFICE VISITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	50% Coinsurance	No limit
Specialist Office Visits (or Home Visits)	50% Coinsurance	No limit
PREVENTIVE CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Well Child Visits and Immunizations	Covered in full/0% cost-sharing	No limit
Adult Annual Physical Examinations	Covered in full/0% cost-sharing	No limit
Adult Immunizations	Covered in full/0% cost-sharing	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full/0% cost-sharing	No limit
Mammography Screenings	Covered in full/0% cost-sharing	No limit
Sterilization Procedures for Women	• Covered in full • 50% Coinsurance	No limit
Vasectomy	• Covered in full • 50% Coinsurance	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	• Covered in full • 50% Coinsurance	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.
Family Planning Services for Women	Covered in full/0% cost-sharing	No limit
All other preventive services required by USPSTF and HRSA under the Affordable Care Act.	Covered in full/0% cost-sharing	No limit
EMERGENCY CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	50% Coinsurance	No limit
Non-Emergency Ambulance Services	50% Coinsurance	No limit
Emergency Department	• 50% Coinsurance • Copayment waived if Hospital admission	No limit
Urgent Care Center	50% Coinsurance	No limit
PROFESSIONAL SERVICES AND OUTPATIENT CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital	50% Coinsurance 50% Coinsurance	No limit

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits		
Services		
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Ambulatory Surgical Center Facility Fee	50% Coinsurance	No limit
Anesthesia Services (all settings)	Covered in full	No limit
Autologous Blood Banking	50% Coinsurance	No limit
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Chiropractic Services	50% Coinsurance	No limit
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 50% Coinsurance 50% Coinsurance 50% Coinsurance	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance	60 visits per condition, per lifetime combined therapies
Home Health Care	50% Coinsurance	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy • Performed in a PCP Office	 50% Coinsurance	No limit

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits		
• Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	50% Coinsurance 50% Coinsurance 50% Coinsurance	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full/0% cost-sharing	No limit
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Maternity & Newborn Care • Prenatal & Postnatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered in full/0% cost-sharing 50% Coinsurance 50% Coinsurance Covered in full/0% cost-sharing	No limit 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early No limit Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	50% Coinsurance	No limit
Preadmission Testing	Covered in full/0% cost-sharing	No limit
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Service	50% Coinsurance 50% Coinsurance	No limit
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance	60 visits per condition, per lifetime combined therapies

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits		
		Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	50% Coinsurance	• One second surgical opinion on the need for surgery • For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 50% Coinsurance 50% Coinsurance 50% Coinsurance 50% Coinsurance	• No limit • Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. • Oral Surgery due to injury is limited to sound and natural teeth only.
Elective Termination of Pregnancy	50% Coinsurance	• 1 Treatment per Year • Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT & DEVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	50% Coinsurance	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	50% Coinsurance	Limited to dedicated devices
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 50% Coinsurance 50% Coinsurance	No limit
Durable Medical Equipment & Braces	50% Coinsurance	Coverage for standard equipment only.
External Hearing Aids	50% Coinsurance	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient	 50% Coinsurance 50% Coinsurance	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance	

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits		
Prosthetic Devices • External • Internal	 50% Coinsurance 50% Coinsurance	One prosthetic device, per limb, per lifetime No limit
INPATIENT SERVICES & FACILITIES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	50% Coinsurance	No limit
Observation Stay	50% Coinsurance	No limit
Bariatric Surgery	50% Coinsurance	No limit
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	50% Coinsurance	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	50% Coinsurance	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	50% Coinsurance	No limit
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	50% Coinsurance	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	50% Coinsurance	No limit
Outpatient Substance Use Services	50% Coinsurance	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Enteral Formula	Use appropriate prescription drug tier cost-sharing	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment $35 Copayment $70 Copayment	No limit
Up to a 90 Day Supply For Maintenance Drugs Tier 1	 $25 Copayment	No limit

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits		
Tier 2 Tier 3	$87.50 Copayment $175 Copayment	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	No limit
WELLNESS BENEFITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Gym Reimbursement	Not Applicable	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC DENTAL &VISION CARE		
	In-Network Cost-Sharing	**Limits**
Pediatric Dental Care • Preventive/Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 50% Coinsurance 50% Coinsurance 50% Coinsurance	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	 50% Coinsurance 50% Coinsurance 50% Coinsurance	 One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period Covered when medically necessary

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits, without Pediatric Dental		
Deductible	**Individual - $3,000; Family - $6,000**	
Max. Out of Pocket Limit	**Individual - $6,350; Family - $12,700**	
OFFICE VISITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	50% Coinsurance	No limit
Specialist Office Visits (or Home Visits)	50% Coinsurance	No limit
PREVENTIVE CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Well Child Visits and Immunizations	Covered in full/0% cost-sharing	No limit
Adult Annual Physical Examinations	Covered in full/0% cost-sharing	No limit
Adult Immunizations	Covered in full/0% cost-sharing	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full/0% cost-sharing	No limit
Mammography Screenings	Covered in full/0% cost-sharing	No limit
Sterilization Procedures for Women	• Covered in full • 50% Coinsurance	No limit
Vasectomy	• Covered in full • 50% Coinsurance	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	• Covered in full • 50% Coinsurance	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.
Family Planning Services for Women	Covered in full/0% cost-sharing	No limit
All other preventive services required by USPSTF and HRSA under the Affordable Care Act.	Covered in full/0% cost-sharing	No limit
EMERGENCY CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	50% Coinsurance	No limit
Non-Emergency Ambulance Services	50% Coinsurance	No limit
Emergency Department	• 50% Coinsurance • Copayment waived if Hospital admission	No limit
Urgent Care Center	50% Coinsurance	No limit
PROFESSIONAL SERVICES AND OUTPATIENT CARE		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	50% Coinsurance 50% Coinsurance	No limit

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits, without Pediatric Dental		
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Ambulatory Surgical Center Facility Fee	50% Coinsurance	No limit
Anesthesia Services (all settings)	Covered in full	No limit
Autologous Blood Banking	50% Coinsurance	No limit
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Chiropractic Services	50% Coinsurance	No limit
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 50% Coinsurance 50% Coinsurance 50% Coinsurance	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance	60 visits per condition, per lifetime combined therapies
Home Health Care	50% Coinsurance	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		No limit

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits, without Pediatric Dental		
• Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	50% Coinsurance 50% Coinsurance 50% Coinsurance 50% Coinsurance	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full/0% cost-sharing	No limit
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Maternity & Newborn Care • Prenatal & Postnatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered in full/0% cost-sharing 50% Coinsurance 50% Coinsurance Covered in full/0% cost-sharing	No limit 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early No limit Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	50% Coinsurance	No limit
Preadmission Testing	Covered in full/0% cost-sharing	No limit
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	50% Coinsurance 50% Coinsurance 50% Coinsurance	No limit
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Service	50% Coinsurance 50% Coinsurance	No limit
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance	60 visits per condition, per lifetime combined therapies

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits, without Pediatric Dental		
		Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	50% Coinsurance	• One second surgical opinion on the need for surgery • For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 50% Coinsurance 50% Coinsurance 50% Coinsurance 50% Coinsurance	• No limit • Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. • Oral Surgery due to injury is limited to sound and natural teeth only.
Elective Termination of Pregnancy	50% Coinsurance	• 1 Treatment per Year • Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT & DEVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	50% Coinsurance	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	50% Coinsurance	Limited to dedicated devices
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 50% Coinsurance 50% Coinsurance	No limit
Durable Medical Equipment & Braces	50% Coinsurance	Coverage for standard equipment only.
External Hearing Aids	50% Coinsurance	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient	 50% Coinsurance 50% Coinsurance	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance	

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits, without Pediatric Dental		
Prosthetic Devices • External • Internal	 50% Coinsurance 50% Coinsurance	 One prosthetic device, per limb, per lifetime No limit
INPATIENT SERVICES & FACILITIES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	50% Coinsurance	No limit
Observation Stay	50% Coinsurance	No limit
Bariatric Surgery	50% Coinsurance	No limit
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	50% Coinsurance	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	50% Coinsurance	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	50% Coinsurance	No limit
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	50% Coinsurance	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	50% Coinsurance	No limit
Outpatient Substance Use Services	50% Coinsurance	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Enteral Formula	Use appropriate prescription drug tier cost-sharing	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment $35 Copayment $70 Copayment	No limit
Up to a 90 Day Supply For Maintenance Drugs Tier 1	 $25 Copayment	No limit

Healthfirst HMO D (& Healthfirst HMO D Child-Only)		
Standard Benefits, without Pediatric Dental		
Tier 2 Tier 3	$87.50 Copayment $175 Copayment	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $25 Copayment $87.50 Copayment $175 Copayment	No limit
WELLNESS BENEFITS		
Benefit Type	**In-Network Cost-Sharing**	**Limits**
Gym Reimbursement	Not Applicable	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC VISION CARE		
	In-Network Cost-Sharing	**Limits**
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	 50% Coinsurance 50% Coinsurance 50% Coinsurance	 One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period Covered when medically necessary

SECTION III – Underwriting Guidelines

For the individual line of business, Healthfirst PHSP, Inc. accepts any individual who applies and is eligible for coverage under an approved individual HMO plan, pursuant to New York State's guaranteed issue laws and their related regulations. With respect to premium rating, Healthfirst PHSP, Inc. offers coverage at the same premium rate (excluding permissible rating region and rating tier adjustments pursuant to the Invitation to Participate in the New York Health Benefit Exchange, dated January 31, 2013) for any individual who applies and is eligible for coverage under an approved individual HMO plan, pursuant to New York State's community rating laws and their related regulations. In addition, Healthfirst's Individual off-Exchange HMO standard plans comply with all applicable federal laws, including the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148) (124 Stat. 119) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (124 Stat. 1029).

SECTION IV – OUTLINE OF MARKETING RULES & METHODS

Healthfirst PHSP, Inc. (Healthfirst) is filing for review and approval one standard plan, along with a corresponding child-only plan, in each metal level in the off-Exchange Individual market for plan year 2014. Direct marketing of these plans, in accordance with federal and New York State law, will be a core component of Healthfirst's marketing plan. Healthfirst's product offerings in both the on- and off-Exchange market represents the company's first major effort in the commercial health insurance market. This expansion opportunity aligns with the company's core mission and vision to insure the underserved of the region, while also keeping health care affordable and accessible for more New Yorkers. An outline of Healthfirst's intended marketing methods is as follows:

I. Major focus on education (pre-open enrollment and ongoing throughout the plan year)
   a. Aligns with and supports overall Healthfirst goals:
      i. To inform and listen to New Yorkers about health reform,
      ii. Educate New Yorkers about how health reform and the Exchange may benefit them, and
      iii. Create awareness about the Exchange, Qualified Health Plans (QHP) offered through the Exchange, and using the Exchange web portal

II. Outreach campaign with multiple touch points to reach target audiences
   a. Will commence in Spring/Summer 2013 to raise awareness leading up to October 2013 open enrollment for on- and off-Exchange products
   b. Continuous community outreach to educate and inform about health reform and newly available coverage options
   c. Outreach will target current Healthfirst members, as well as individuals potentially eligible for any program/plan accessible through the Exchange portal
   d. Information will be communicated in multiple languages, including, but not limited to, Spanish, Chinese, and other languages as needed
   e. Touch point tactics will include Healthfirst microsite, website messaging, member portal communication, web ads and banners, fliers, brochures, community-based organization partnerships, social media, Healthfirst community-based offices, email, text messaging, community events, and local newspapers, among others.

III. Will disseminate/distribute content that is written in a way that is clear, simple, and quick to read. It will be written "in voice" of the target population, and at a 4th-grade reading level.

IV. Continuous engagement
   a. Outside open enrollment period, engage with current and prospective members
   b. Disseminate education and updates on federal health reform and New York-specific actions and activity