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Managed Health, Inc.

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name:

MHI Healthy NY Small Group HMO

Project Name/Number:

/

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		MHI Healthy NY Small Group Rate Manual 2014		New		MHI_Rate Manual_Healthy NY Small Group 2014_v2.pdf,



June 14, 2013

John Powell
Director, Rate Review
Health Bureau
New York State Department of Financial Services
One State Street
New York, NY 10004

**RE: Managed Health, Inc. – Healthy NY Small Group
Submission Effective January 1, 2014
Rates and Forms Application Under New York State Insurance Law Section 4308(c)**

Dear Mr. Powell:

Managed Health, Inc. is pleased to submit its Healthy New York HMO small group premium rates and forms for an effective date of January 1, 2014.

Pursuant to the Review Standards for Major Medical and Other Similar-Type Comprehensive Health Insurance for Small Groups Checklist, dated April 22, 2013, enclosed please find the rate manual for this submission, which includes the requested elements and sections.

These rates and forms are for participation in New York, Richmond, Kings, Queens, Bronx, Nassau, and Suffolk counties. There are no broker/agent commissions associated with this product, therefore a commission schedule was intentionally not included in this rate manual.

If you have any questions regarding this rates and forms submission please feel free to contact Shawn Nowicki, Director, Regulatory Affairs, with inquiries relating to forms or Adrian Kryszak, Director, Actuarial Services, with inquiries relating to rates at (212) 801-6210 and (212) 497-4337, respectively. Thank you for your time and consideration. We look forward to working with you.

Sincerely,

A handwritten signature in black ink that reads "Angela Liang".

Angela Liang, FSA, MAAA
VP, Actuarial Services

Managed Health, Inc. D/B/A Healthfirst Healthy NY
Rate Manual Pursuant to New York Insurance Law Section 4308(c)
Healthy NY Small Group HMO Rates and Forms Submission
Effective January 1, 2014

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**SECTION I –
Healthy NY Small Group HMO
Standard Plan Rates**

Section I.A – Rate Pages

**MANAGED HEALTH, INC. D/B/A Healthfirst Healthy NY
HEALTHY NY SMALL GROUP HMO STANDARD PLANS**

RATE PAGES - EFFECTIVE JANUARY 1, 2014

AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, AND SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES – STANDARD PLAN (WITH PEDIATRIC DENTAL & FAMILY PLANNING)

PLAN NAME	Healthfirst Healthy NY	With Dependent to Age 29 Rider
METAL LEVEL	Gold	Gold
<i>Single</i>	\$540.61	\$558.45
<i>Single + spouse</i>	\$1,081.21	\$1,116.89
<i>Single + child(ren)</i>	\$919.03	\$949.36
<i>Single + spouse + child(ren)</i>	\$1,540.73	\$1,591.57

Form Numbers of policies to which these rates apply:

Healthfirst Healthy NY
MHI-HNY-SG-GD-NDPNFP-14 MHI-HNY-DPR-14 MHI-HNY-FPR-14 MHI-HNY-A29R-14

PROPOSED HMO PREMIUM RATES – STANDARD PLAN (NO PEDIATRIC DENTAL, WITH FAMILY PLANNING)

PLAN NAME	Healthfirst Healthy NY	With Dependent to Age 29 Rider
METAL LEVEL	Gold	Gold
<i>Single</i>	\$536.82	\$554.53
<i>Single + spouse</i>	\$1,073.63	\$1,109.06
<i>Single + child(ren)</i>	\$912.59	\$942.70
<i>Single + spouse + child(ren)</i>	\$1,529.93	\$1,580.41

Form Numbers of policies to which these rates apply:

Healthfirst Healthy NY
MHI-HNY-SG-GD-NDPNFP-14 MHI-HNY-DPR-14 MHI-HNY-FPR-14 MHI-HNY-A29R-14

**MANAGED HEALTH, INC. D/B/A Healthfirst Healthy NY
HEALTHY NY SMALL GROUP HMO STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2014**

AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, AND SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES – STANDARD PLAN (NO PEDIATRIC DENTAL, NO FAMILY PLANNING)

PLAN NAME	Healthfirst Healthy NY	With Dependent to Age 29 Rider
METAL LEVEL	Gold	Gold
<i>Single</i>	\$534.97	\$552.62
<i>Single + spouse</i>	\$1,069.94	\$1,105.24
<i>Single + child(ren)</i>	\$909.45	\$939.46
<i>Single + spouse + child(ren)</i>	\$1,524.66	\$1,574.97

Form Numbers of policies to which these rates apply:

Healthfirst Healthy NY
MHI-HNY-SG-GD-NDPNFP-14 MHI-HNY-DPR-14 MHI-HNY-A29R-14

PROPOSED HMO PREMIUM RATES – STANDARD PLAN (WITH PEDIATRIC DENTAL, NO FAMILY PLANNING)

PLAN NAME	Healthfirst Healthy NY	With Dependent to Age 29 Rider
METAL LEVEL	Gold	Gold
<i>Single</i>	\$538.74	\$556.52
<i>Single + spouse</i>	\$1,077.49	\$1,113.05
<i>Single + child(ren)</i>	\$915.87	\$946.09
<i>Single + spouse + child(ren)</i>	\$1,535.42	\$1,586.09

Form Numbers of policies to which these rates apply:

Healthfirst Healthy NY
MHI-HNY-SG-GD-NDPNFP-14 MHI-HNY-DPR-14 MHI-HNY-A29R-14

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

Managed Health, 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: dependent age limit, the inclusion of a pediatric dental benefit, the inclusion of family planning benefits, and family/census tier.

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

Rating Region

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

Pediatric Dental Benefit

Pediatric Dental Benefit	Cost Factor
Included	1.000
Not Included	0.993

Family Planning Benefits

Family Planning Rider	Cost Factor
Included	1.000
Not Included	0.997

Dependent Age Limit

Dependent Age Limit	Cost Factor
26	1.000
29	1.033

Domestic Partner Coverage

Domestic Partner	Cost Factor
Covered	1.000
Not Covered	1.000

Section I.C – Rate Calculation Examples

The entirety of premium rates for Managed Health, Inc.'s Healthy NY Small Group plans is listed above in the rate tables in section I.A (pages 5-8 of this rate manual). An example of how to look up a particular premium rate is below.

EXAMPLE:

Consumer Profile: A married employee (subscriber), of a Queens County-based employer, who is electing to cover his spouse and two children as dependents, is choosing the Healthfirst Healthy NY product with pediatric dental benefits and family planning 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 subscriber 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 & Family Planning)." Next, the consumer would refer to the column labeled, "Healthfirst Healthy NY" and cross-reference the row labeled, "Single + Spouse + Child(ren)." The rate for this plan is \$1,577.32 per month.

Section I.D – 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 86.4%. 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

Section II.A – Small Group Gold Standard Plan Benefit Description

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Plan (with Pediatric Dental & Family Planning)		
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	<ul style="list-style-type: none"> • Covered in full • \$40 Copayment 	No limit
Vasectomy	<ul style="list-style-type: none"> • Covered in full • \$40 Copayment 	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • \$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		No limit

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Plan (with Pediatric Dental & Family Planning)		
<ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting 	\$40 Copayment	
<ul style="list-style-type: none"> 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		No limit
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25 Copayment	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$25 Copayment	
<ul style="list-style-type: none"> Performed as Inpatient Hospital Services 	\$1,000 Copayment per admission	
Chemotherapy		No limit
<ul style="list-style-type: none"> Performed in a PCP Office 	\$25 Copayment	
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25 Copayment	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$25 Copayment	
Chiropractic Services	\$40 Copayment	No limit
Diagnostic Testing		No limit
<ul style="list-style-type: none"> Performed in a PCP Office 	\$25 Copayment	
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$40 Copayment	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$40 Copayment	
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
<ul style="list-style-type: none"> Performed in a PCP Office 	\$25 Copayment	
<ul style="list-style-type: none"> Performed in a Freestanding Center or Specialist Office Setting 	\$25 Copayment	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$25 Copayment	
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	<ul style="list-style-type: none"> Member must be between ages of 21 and 44

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Plan (with Pediatric Dental & Family Planning)		
	Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	<ul style="list-style-type: none"> Advanced infertility not covered
Infusion Therapy <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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		No limit

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Plan (with Pediatric Dental & Family Planning)		
<ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office 	\$25 Copayment	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Service 	\$25 Copayment	
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	<ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery 	\$100 Copayment \$100 Copayment \$100 Copayment \$40 Copayment	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Plan (with Pediatric Dental & Family Planning)		
		only.
External Hearing Aids	20% Coinsurance	<ul style="list-style-type: none"> • Single Purchase Once Every 3 Years
Cochlear Implants	20% Coinsurance	One Per Ear Per Time Covered
Hospice Care		
<ul style="list-style-type: none"> • Inpatient 	\$1000 Copayment per admission	210 Days per Plan Year
<ul style="list-style-type: none"> • Outpatient 	\$25 Copayment	5 Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance	
Prosthetic Devices		
<ul style="list-style-type: none"> • External 	20% Coinsurance	One prosthetic device, per limb, per lifetime
<ul style="list-style-type: none"> • Internal 	20% Coinsurance	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	\$1000 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	30 day supply per month

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Plan (with Pediatric Dental & Family Planning)		
	drug tier cost-sharing	
Retail Pharmacy		
30 Day Supply		No limit
Tier 1	\$10 Copayment	
Tier 2	\$35 Copayment	
Tier 3	\$70 Copayment	
Up to a 90 Day Supply For Maintenance Drugs		No limit
Tier 1	\$25 Copayment	
Tier 2	\$87.50 Copayment	
Tier 3	\$175 Copayment	
Mail Order Pharmacy		
Up to a 90 Day Supply		No limit
Tier 1	\$25 Copayment	
Tier 2	\$87.50 Copayment	
Tier 3	\$175 Copayment	
WELLNESS BENEFITS		
Benefit Type	In-Network Cost-Sharing	Limits
Gym Reimbursement	Not Applicable	<ul style="list-style-type: none"> 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		
<ul style="list-style-type: none"> Preventive/Routine Dental Care 	\$25 Copayment	One Dental Exam & Cleaning Per 6-Month Period
<ul style="list-style-type: none"> Major Dental (Endodontics & Prosthodontics) 	\$25 Copayment	
<ul style="list-style-type: none"> Orthodontia 	\$25 Copayment	
Pediatric Vision Care		
<ul style="list-style-type: none"> Exams 	\$25 Copayment	One Exam Per 12-Month Period;
<ul style="list-style-type: none"> Lenses & Frames 	20% Coinsurance	One Prescribed Lenses & Frames in a 12-Month Period

Managed Health Inc. D/B/A Healthfirst
HMO B Small Group

Standard Plan (with Pediatric Dental & Family Planning)

• Contact Lenses	20% Coinsurance	Covered when medically necessary
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**Section II.B – Small Group Gold Standard Plan, without Pediatric Dental,
Benefit Description**

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Benefits, without Pediatric Dental & with Family Planning		
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	<ul style="list-style-type: none"> Covered in full \$40 Copayment 	No limit
Vasectomy	<ul style="list-style-type: none"> Covered in full \$40 Copayment 	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> \$150 Copayment Copayment waived if Hospital admission 	No limit
Urgent Care Center	\$60 Copayment	No limit

**Managed Health Inc. D/B/A Healthfirst
HMO B Small Group**

Standard Benefits, without Pediatric Dental & with Family Planning

PROFESSIONAL SERVICES AND OUTPATIENT CARE

Benefit Type	In-Network Cost-Sharing	Limits
Advanced Imaging Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services 	\$40 Copayment \$40 Copayment	No limit
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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	\$25 Copayment \$40 Copayment \$40 Copayment	No limit
Dialysis <ul style="list-style-type: none"> 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,	\$30 Copayment	60 visits per condition, per lifetime

**Managed Health Inc. D/B/A Healthfirst
HMO B Small Group**

Standard Benefits, without Pediatric Dental & with Family Planning

Occupational Therapy or Speech Therapy)		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 Procedures)	<ul style="list-style-type: none"> • Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding 	\$25 Copayment \$40 Copayment	No limit

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Benefits, without Pediatric Dental & with Family Planning		
Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	\$40 Copayment	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Service	\$25 Copayment \$25 Copayment	No limit
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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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		No limit

**Managed Health Inc. D/B/A Healthfirst
HMO B Small Group**

Standard Benefits, without Pediatric Dental & with Family Planning

• Diabetic Equipment, Supplies and Insulin (30-Day Supply)	\$25 Copayment	
• Diabetic Education	\$25 Copayment	
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
Hospice Care		
• Inpatient	\$1000 Copayment per admission	210 Days per Plan Year
• Outpatient	\$25 Copayment	5 Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance	
Prosthetic Devices		
• External	20% Coinsurance	One prosthetic device, per limb, per lifetime
• Internal	20% Coinsurance	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	\$1000 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

**Managed Health Inc. D/B/A Healthfirst
HMO B Small Group**

Standard Benefits, without Pediatric Dental & with Family Planning

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		No limit
Tier 1	\$10 Copayment	
Tier 2	\$35 Copayment	
Tier 3	\$70 Copayment	
Up to a 90 Day Supply For Maintenance Drugs		No limit
Tier 1	\$25 Copayment	
Tier 2	\$87.50 Copayment	
Tier 3	\$175 Copayment	
Mail Order Pharmacy		
Up to a 90 Day Supply		No limit
Tier 1	\$25 Copayment	
Tier 2	\$87.50 Copayment	
Tier 3	\$175 Copayment	
WELLNESS BENEFITS		
Benefit Type	In-Network Cost-Sharing	Limits
Gym Reimbursement	Not Applicable	<ul style="list-style-type: none"> 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		
Pediatric Vision Care	In-Network Cost-Sharing	Limits
<ul style="list-style-type: none"> Exams 	\$25 Copayment	One Exam Per 12-Month Period;
<ul style="list-style-type: none"> Lenses & Frames 	20% Coinsurance	One Prescribed Lenses & Frames in a 12-Month Period
<ul style="list-style-type: none"> Contact Lenses 	20% Coinsurance	Covered when medically necessary

Section II.C – Small Group Gold Standard Plan, without Pediatric Dental and without Family Planning, Benefit Description

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Benefits, without Pediatric Dental and without Family Planning		
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	Not covered	No limit
Vasectomy	Not covered	No limit
Bone Density Testing	Covered in full/0% cost-sharing	No limit
Screening for Prostate Cancer	<ul style="list-style-type: none"> 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	Not covered	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	<ul style="list-style-type: none"> \$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

**Managed Health Inc. D/B/A Healthfirst
HMO B Small Group**

Standard Benefits, without Pediatric Dental and without Family Planning

Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	\$40 Copayment \$40 Copayment	No limit
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

**Managed Health Inc. D/B/A Healthfirst
HMO B Small Group**

Standard Benefits, without Pediatric Dental and without Family Planning

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 Procedures)	<ul style="list-style-type: none"> Member must be between ages of 21 and 44 Advanced infertility not covered
Infusion Therapy <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office 	\$25 Copayment \$40 Copayment \$40 Copayment	No limit

**Managed Health Inc. D/B/A Healthfirst
HMO B Small Group**

Standard Benefits, without Pediatric Dental and without Family Planning

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 		
Therapeutic Radiology Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office 	\$25 Copayment	No limit
<ul style="list-style-type: none"> Performed as Outpatient Hospital Service 	\$25 Copayment	
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	<ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery 	\$100 Copayment \$100 Copayment \$100 Copayment \$40 Copayment	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (30-Day Supply) 	\$25 Copayment	No limit

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Benefits, without Pediatric Dental and without Family Planning		
• Diabetic Education	\$25 Copayment	
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
Hospice Care		
• Inpatient	\$1000 Copayment per admission	210 Days per Plan Year
• Outpatient	\$25 Copayment	5 Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance	
Prosthetic Devices		
• External	20% Coinsurance	One prosthetic device, per limb, per lifetime
• Internal	20% Coinsurance	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	\$1000 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

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Benefits, without Pediatric Dental and without Family Planning		
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		No limit
Tier 1	\$10 Copayment	
Tier 2	\$35 Copayment	
Tier 3	\$70 Copayment	
Up to a 90 Day Supply For Maintenance Drugs		No limit
Tier 1	\$25 Copayment	
Tier 2	\$87.50 Copayment	
Tier 3	\$175 Copayment	
Mail Order Pharmacy		
Up to a 90 Day Supply		No limit
Tier 1	\$25 Copayment	
Tier 2	\$87.50 Copayment	
Tier 3	\$175 Copayment	
WELLNESS BENEFITS		
Benefit Type	In-Network Cost-Sharing	Limits
Gym Reimbursement	Not Applicable	<ul style="list-style-type: none"> 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		
<ul style="list-style-type: none"> Exams 	\$25 Copayment	One Exam Per 12-Month Period;
<ul style="list-style-type: none"> Lenses & Frames 	20% Coinsurance	One Prescribed Lenses & Frames in a 12-Month Period
<ul style="list-style-type: none"> Contact Lenses 	20% Coinsurance	Covered when medically necessary

SECTION III – Underwriting Guidelines

For the Small Group line of business, including Healthy NY products, Managed Health, Inc. accepts any small group, and its employees and dependents, that applies and is eligible for coverage under an approved small group HMO plan, pursuant to New York State's guaranteed issue laws and their related regulations. With respect to premium rating, Managed Health, Inc. offers coverage at the same premium rate (excluding permissible rating region and rating tier adjustments pursuant to New York State law) for any small group that 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, Managed Health, Inc.'s Healthy NY small group HMO standard plan complies 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).