Managed Health, Inc. D/B/A Healthfirst

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

Small Group Off-Exchange HMO Rates and Forms Submission

Effective January 1, 2014

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SECTION I –

Small Group Off-Exchange HMO

Standard Plan Rates

Section I.A – Rate Pages

MANAGED HEALTH, INC. D/B/A Healthfirst
OFF-EXCHANGE 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 HMO B Small Group	With Dependent to Age 29 Rider
METAL LEVEL	Gold	Gold
Single	$616.73	$637.08
Single + spouse	$1,233.45	$1,274.16
Single + child(ren)	$1,048.43	$1,083.03
Single + spouse + child(ren)	$1,757.67	$1,815.67

Form Numbers of policies to which these rates apply:

Healthfirst HMO B Small Group
MHI-SG-14-OFF
MHI-DPR-14-OFF
MHI-FPR-14-OFF
MHI-A29R-14-OFF

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

PLAN NAME	Healthfirst HMO B Small Group	With Dependent to Age 29 Rider
METAL LEVEL	Gold	Gold
Single	$612.40	$632.61
Single + spouse	$1,224.81	$1,265.22
Single + child(ren)	$1,041.08	$1,075.44
Single + spouse + child(ren)	$1,745.35	$1,802.94

Form Numbers of policies to which these rates apply:

Healthfirst HMO B Small Group
MHI-SG-14-OFF
MHI-DPR-14-OFF
MHI-FPR-14-OFF
MHI-A29R-14-OFF

MANAGED HEALTH, INC. D/B/A Healthfirst
OFF-EXCHANGE 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 HMO B Small Group	With Dependent to Age 29 Rider
METAL LEVEL	Gold	Gold
Single	$610.29	$630.43
Single + spouse	$1,220.59	$1,260.87
Single + child(ren)	$1,037.50	$1,071.74
Single + spouse + child(ren)	$1,739.34	$1,796.74

Form Numbers of policies to which these rates apply:

Healthfirst HMO B Small Group
MHI-SG-14-OFF
MHI-DPR-14-OFF
MHI-A29R-14-OFF

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

PLAN NAME	Healthfirst HMO B Small Group	With Dependent to Age 29 Rider
METAL LEVEL	Gold	Gold
Single	$614.60	$634.88
Single + spouse	$1,229.21	$1,269.77
Single + child(ren)	$1,044.83	$1,079.30
Single + spouse + child(ren)	$1,751.62	$1,809.42

Form Numbers of policies to which these rates apply:

Healthfirst HMO B Small Group
MHI-SG-14-OFF
MHI-DPR-14-OFF
MHI-A29R-14-OFF

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 Small Group off-Exchange 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 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 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 HMO B Small Group" and cross-reference the row labeled, "Single + Spouse + Child(ren)." The rate for this plan is $1,799.42 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 86.1%. The expected loss ratio under New York State's MLR methodology is 82.1%. 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	• 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		No limit

Managed Health Inc. D/B/A Healthfirst HMO B Small Group Standard Plan (with Pediatric Dental & Family Planning)		
• Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	$40 Copayment $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	• 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)	• Advanced infertility not covered
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		No limit

Managed Health Inc. D/B/A Healthfirst HMO B Small Group		
Standard Plan (with Pediatric Dental & Family Planning)		
• Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Service	$25 Copayment $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	• 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

Managed Health Inc. D/B/A Healthfirst HMO B Small Group Standard Plan (with Pediatric Dental & Family Planning)		
		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 • 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	$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 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 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	 $25 Copayment 20% Coinsurance	 One Exam Per 12-Month Period; 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

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	• 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

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 • 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,	$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)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
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	 $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	• 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		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) • Diabetic Education	$25 Copayment $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 • 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	$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 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 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 – 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	• 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	• $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)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
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	 $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		
• Performed as Outpatient Hospital Services		
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	• 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)	$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 • 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	$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 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 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 III – Underwriting Guidelines

For the Small Group line of business, Managed Health, Inc. accepts any small group, and it's 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 small group 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).