Filing at a Glance

Company:	Healthfirst PHSP, Inc.
Product Name:	Healthfirst PHSP On-Exchange Individual 2015 Rate Filing
State:	New York
TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02I.005D Individual - HMO
Filing Type:	Prior Approval Exchange Form & Rate Filing
Date Submitted:	06/13/2014
SERFF Tr Num:	HLFT-129571607
SERFF Status:	Assigned
State Tr Num:	2014060271
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2015
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *New York* **Filing Company:** *Healthfirst PHSP, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Healthfirst PHSP On-Exchange Individual 2015 Rate Filing*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: [redacted]

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 06/16/2014
State Status Changed:
Created By: [redacted]
Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null
Exchange Intentions: 2015 on-Exchange individual products.

Filing Description:
Healthfirst PHSP, Inc.'s initial submission of its 2015 Individual on-Exchange rate filing.

This filing includes both standard and non-standard plans. The standard plans are currently in-force (for plan year 2014), and the non-standard plans are new for 2015. The non-standard plans vary from their standard counterparts only in the addition of adult vision and adult dental. Cost-sharing structures are the same between standard and non-standard plans.

The SERFF tracking number of the associated form filing is: HLFT-129571500.

The SERFF tracking number and State tracking number of the corresponding Prior Approval prefiling are HLFT-129571500, and 2014060079, respectively.

Company and Contact

Filing Contact Information

[redacted]

Filing Company Information

Healthfirst PHSP, Inc.
100 Church Street
18th Floor
New York, NY 10007
[redacted]

CoCode: 15071
Group Code: 4778
Group Name: Healthfirst Inc Grp
FEIN Number: 13-3783732

State of Domicile: New York
Company Type:
State ID Number: M0134

Filing Fees

Fee Required? No
Retaliatory? No

Fee Explanation:

State Specific

1. Is a parallel product being submitted for another issuing entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: HMO
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): Yes, Statutory Individual HMO
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is a group prefiling notification, out-of-state, or a report filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Form and Rate
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: No
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): Yes. SERFF tracking number: HLFT-129571500. State tracking number: 2014060079

Rate Information

Rate data applies to filing.

Filing Method:
Rate Change Type: Decrease
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Healthfirst PHSP, Inc.	Decrease	%	%				%	%

State: *New York* **Filing Company:** *Healthfirst PHSP, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Healthfirst PHSP On-Exchange Individual 2015 Rate Filing*
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		Healthfirst PHSP, Inc. QHP Individual On-Exchange Rate Manual		New		Healthfirst PHSP_Rate Manual_QHPs On Exchange for 2015 (new) 2.pdf,

healthfirst

June 13, 2014

Health Bureau
New York State Department of Financial Services
One State Street
New York, NY 10004

RE: Healthfirst PHSP, Inc. – Individual On-Exchange Plans
Submission Effective January 1, 2015
Rates and Forms Application

Dear

Healthfirst PHSP, Inc. is pleased to submit its premium rates and forms for certification for participation in NY State of Health for an effective date of January 1, 2015. The standard products listed herein are existing products and are therefore being filed pursuant to section 4308(c) of the NY Insurance Law.

Enclosed please find the rate manual for this submission. Broker/agent commissions are not applied to these rates.

These rates and forms are for participation in New York, Richmond, Kings, Queens, Bronx, Nassau, and Suffolk Counties.

If you have any questions regarding this on-Exchange rates and forms submission please feel free to contact respectively. Thank you for your time and consideration. We look forward to working with you and the New York State of Health.

HEALTHFIRST PHSP, INC.

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

On-Exchange Individual HMO Rates and Forms Submission

Effective January 1, 2015

TABLE OF CONTENTS

I. Individual On-Exchange Plan Rates **4**

- **A.** Rate Pages – Standard Plans **6**
- **B.** Rate Pages – Non-Standard Plans **8**
- **C.** Description of Rating Classes, Factors, and Premium Discounts **10**
- **D.** Rate Calculation Examples **11**
- **E.** Expected Loss Ratio(s) **12**

II. Description of Benefits, Types of Coverage, Limitations, Exclusions, Issue Limits, and Renewal Conditions **13**

- **A.** Healthfirst Platinum Standard Plan **14**
- **B.** Healthfirst Gold Standard Plan **24**
- **C.** Healthfirst Silver Standard Plan **34**
  - **i.** 100-150% FPL Silver CSR Standard Plan **44**
  - **ii.** 150-200% FPL Silver CSR Standard Plan **54**
  - **iii.** 200-250% FPL Silver CSR Standard Plan **64**
- **D.** Healthfirst Bronze Standard Plan **74**
- **E.** Healthfirst Catastrophic Standard Plan **84**
- **F.** Healthfirst Native American/Alaska Native CSR Standard Plan **94**
- **G.** Healthfirst Platinum Non-Standard Plan **103**
- **H.** Healthfirst Gold Non-Standard Plan **113**
- **I.** Healthfirst Silver Non-Standard Plan **123**
  - **i.** 100-150% FPL Silver CSR Non-Standard Plan **133**

ii. 150-200% FPL Silver CSR Non-Standard Plan……**143**

iii. 200-250% FPL Silver CSR Non-Standard Plan……**153**

J. Healthfirst Bronze Non-Standard Plan…… **163**

K. Healthfirst Native American/Alaska Native CSR Non-Standard Plan……. **173**

III. Underwriting Guidelines…….. **182**

SECTION I –

On-Exchange Individual HMO Plan Rates

Section I.A – Rate Pages: Standard Plans

HEALTHFIRST PHSP, INC.
ON-EXCHANGE INDIVIDUAL HMO STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, & SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES – STANDARD PLANS

PLAN NAME	Healthfirst Platinum Leaf	Healthfirst Gold Leaf	Healthfirst Silver Leaf	Healthfirst Bronze Leaf	Healthfirst Green Leaf
METAL LEVEL	Platinum	Gold	Silver	Bronze	Catastrophic
Single	$551.37	$465.25	$397.48	$339.11	$210.03
Single + spouse	$1,102.74	$930.50	$794.96	$678.21	$420.07
Single + child(ren)	$937.33	$790.93	$675.71	$576.48	$357.06
Single + spouse + child(ren)	$1,571.41	$1,325.97	$1,132.81	$966.45	$598.60

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf	Healthfirst Gold Leaf	Healthfirst Silver Leaf	Healthfirst Bronze Leaf	Healthfirst Green Leaf
HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDCC-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15	HF-CCSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15	HF-NoCSSOB-15
		HF-S150SOB-15		
		HF-S200SOB-15		
		HF-NoCSSOB-15		

Age 29 Rider (additional cost to the base premium rate)

PLAN NAME	Healthfirst Platinum Leaf	Healthfirst Gold Leaf	Healthfirst Silver Leaf	Healthfirst Bronze Leaf
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$5.51	$4.65	$3.97	$3.39
Single + spouse	$11.03	$9.31	$7.95	$6.78
Single + child(ren)	$9.37	$7.91	$6.76	$5.76
Single + spouse + child(ren)	$15.71	$13.26	$11.33	$9.66

HEALTHFIRST PHSP, INC.
ON-EXCHANGE INDIVIDUAL HMO STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, & SUFFOLK COUNTIES

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf	Healthfirst Gold Leaf	Healthfirst Silver Leaf	Healthfirst Bronze Leaf
HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDIND-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15
HF-A29R-15	HF-A29R-15	HF-S150SOB-15	HF-A29R-15
		HF-S200SOB-15	
		HF-NoCSSOB-15	
		HF-A29R-15	

Child-only

PLAN NAME	Healthfirst Platinum Leaf Child-Only	Healthfirst Gold Leaf Child-Only	Healthfirst Silver Leaf Child-Only	Healthfirst Bronze Leaf Child-Only
METAL LEVEL	Platinum	Gold	Silver	Bronze
One Child	$227.16	$191.68	$163.76	$139.71
Two Children	$454.32	$383.36	$327.52	$279.42
Three or More Children	$681.48	$575.04	$491.28	$419.13

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf Child-Only	Healthfirst Gold Leaf Child-Only	Healthfirst Silver Leaf Child-Only	Healthfirst Bronze Leaf Child-Only
HF-STDCO-15	HF-STDCO-15	HF-STDCO-15	HF-STDCO-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15
		HF-S150SOB-15	
		HF-S200SOB-15	
		HF-NoCSSOB-15	

Section I.B – Rate Pages: Non-Standard Plans

HEALTHFIRST PHSP, INC.
ON-EXCHANGE INDIVIDUAL HMO NON-STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, & SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES: NON-STANDARD PLANS

PLAN NAME	Healthfirst Platinum Leaf Premier	Healthfirst Gold Leaf Premier	Healthfirst Silver Leaf Premier	Healthfirst Bronze Leaf Premier
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$569.75	$480.76	$410.72	$350.41
Single + spouse	$1,139.49	$961.51	$821.45	$700.81
Single + child(ren)	$968.57	$817.29	$698.23	$595.69
Single + spouse + child(ren)	$1,623.78	$1,370.16	$1,170.56	$998.66

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf Premier	Healthfirst Gold Leaf Premier	Healthfirst Silver Leaf Premier	Healthfirst Bronze Leaf Premier
HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDIND-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15
		HF-S150SOB-15	
		HF-S200SOB-15	
		HF-NoCSSOB-15	

Age 29 Rider (additional cost to the base premium rate)

PLAN NAME	Healthfirst Platinum Leaf Premier	Healthfirst Gold Leaf Premier	Healthfirst Silver Leaf Premier	Healthfirst Bronze Leaf Premier
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$5.69	$4.80	$4.11	$3.50
Single + spouse	$11.39	$9.62	$8.21	$7.01
Single + child(ren)	$9.67	$8.17	$6.98	$5.96
Single + spouse + child(ren)	$16.24	$13.70	$11.70	$9.99

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf Premier	Healthfirst Gold Leaf Premier	Healthfirst Silver Leaf Premier	Healthfirst Bronze Leaf Premier
HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDIND-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15
HF-A29R-15	HF-A29R-15	HF-S150SOB-15	HF-A29R-15
		HF-S200SOB-15	
		HF-NoCSSOB-15	
		HF-A29R-15	

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, 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**

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

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

Section I.D – Rate Calculation Example

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 5-9 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 Queens County choosing the Gold Standard Plan, 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 6 and refer to the first table under the heading "Proposed HMO Premium Rates – Standard Plans." Next, the consumer would refer to the column labeled, "Healthfirst Gold Leaf" and cross-reference the row labeled, "Single + Child(ren)." The rate for this plan is $790.93 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 86.4%. The expected loss ratio under New York State's MLR methodology is 84.2%. 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

***Note**: the standard benefit plan grids apply to the plan name listed, as well as its corresponding child-only standard plan (listed in parenthesis).

Section II.A – Platinum Standard Plan Benefit Description

Healthfirst Platinum Leaf (and Healthfirst Platinum Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$0**	
Family	**$0**	
Out-of-Pocket Limit		
Individual	**$2,000**	
Family	**$4,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$15 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$35 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$35 Copayment**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$100 Copayment**	**No limit**
Emergency Department	**$100 Copayment** **Copayment / Coinsurance waived if Hospital admission**	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$35 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Chiropractic Services	$35 Copayment	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Specialist Office	$35 Copayment	No limit
Performed as Outpatient Hospital Services	$35 Copayment	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$15 Copayment	
Performed in a Freestanding Center or Specialist Office	$15 Copayment	

Setting		
Performed as Outpatient Hospital Services	$15 Copayment	
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 Procedures)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		
Performed in a PCP Office	$15 Copayment	No limit
Performed in Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Home Infusion Therapy	$15 Copayment	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$35 Copayment	No limit
Performed as Outpatient Hospital Services	$35 Copayment	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$500 Copayment per admission**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$15 Copayment**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$35 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$15 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment**	**No limit**
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 and 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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
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 and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$15 Copayment**	**No limit**
Diabetic Education	**$15 Copayment**	**No limit**
Durable Medical Equipment and Braces	**10% Coinsurance**	**Coverage for standard equipment only.**
External Hearing Aids	**10% Coinsurance**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**10% Coinsurance**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$500 Copayment per admission**	**210 Days per Plan Year**
Outpatient	**$15 Copayment**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**10% Coinsurance**	
Prosthetic Devices		
External	**10% Coinsurance**	**One prosthetic device, per limb, per lifetime**
Internal	**10% Coinsurance**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**$100 Copayment**	**No limit**

Bariatric Surgery	**$100 Copayment**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$500 Copayment per admission**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$500 Copayment per admission**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
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 and Intensive Outpatient Program Services)	**$15 Copayment**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions**	**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	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$30 Copayment**	**No limit**
Tier 3	**$60 Copayment**	**No limit**
Up to a 90-day supply for Maintenance Drugs		

Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$90 Copayment**	**No limit**
Tier 3	**$180 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$75 Copayment**	**No limit**
Tier 3	**$150 Copayment**	**No limit**
Enteral Formulas	**10% Coinsurance**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$15 Copayment**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$15 Copayment**	
Major Dental (Endodontics, Periodontics and	**$15 Copayment**	

Prosthodontics)		
Orthodontics	**$15 Copayment**	
Pediatric Vision Care		
Exams	**$15 Copayment**	**One Exam Per 12-Month Period**
Lenses and Frames	**10% Coinsurance**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**10% Coinsurance**	

Section II.B – Gold Standard Plan Benefit Description

Healthfirst Gold Leaf (and Healthfirst Gold Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$600**	
Family	**$1,200**	
Out-of-Pocket Limit		
Individual	**$4,000**	
Family	**$8,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$25 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$40 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$40 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$40 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$25 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in a Specialist Office	$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$25 Copayment after deductible	No limit
Chiropractic Services	$40 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in a Specialist Office	$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$40 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$25 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$25 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$25 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$25 Copayment after deductible	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	$25 Copayment after deductible	No limit
Performed in Specialist Office	$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$25 Copayment after deductible	No limit
Home Infusion Therapy	$25 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$40 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,000 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$40 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$25 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$25 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$25 Copayment after deductible**	**No limit**
Diabetic Education	**$25 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**20% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**20% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**20% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,000 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$25 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**20% Coinsurance after deductible**	
Prosthetic Devices		
External	**20% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**20% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,000 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,000 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,000 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$25 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$25 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**20% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$25 Copayment after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$25 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$25 Copayment after deductible**	
Orthodontics	**$25 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$25 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**20% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**20% Coinsurance after deductible**	

Section II.C – Silver Standard Plan Benefit Description

Healthfirst Silver Leaf (and Silver Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$2,000**	
· **Family**	**$4,000**	
Out-of-Pocket Limit		
· **Individual**	**$5,500**	
· **Family**	**$11,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$30 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$50 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$50 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$50 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Chiropractic Services	**$50 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$30 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office	**$30 Copayment after deductible**	

Setting		
Performed as Outpatient Hospital Services	$30 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment after deductible	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	$30 Copayment after deductible	No limit
Performed in Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Home Infusion Therapy	$30 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,500 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$50 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$30 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$30 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$30 Copayment after deductible**	**No limit**
Diabetic Education	**$30 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**30% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**30% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**30% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,500 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$30 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**30% Coinsurance after deductible**	
Prosthetic Devices		
External	**30% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**30% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,500 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,500 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,500 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$30 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$30 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**30% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$30 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$30 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$30 Copayment after deductible**	
Orthodontics	**$30 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$30 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**30% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**30% Coinsurance after deductible**	

Section II.C.i – Silver 100-150% FPL CSR Standard Plan Benefit Description

Healthfirst Silver Leaf CSR 100-150 (and Silver Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$0**	
· **Family**	**$0**	
Out-of-Pocket Limit		
· **Individual**	**$1,000**	
· **Family**	**$2,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$10 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$20 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$20 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$20 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$50 Copayment after deductible**	**No limit**
Emergency Department	**$50 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$25 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$10 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$10 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$10 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$10 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$10 Copayment after deductible**	**No limit**
Chiropractic Services	**$20 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$10 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$10 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office	**$10 Copayment after deductible**	

Setting		
Performed as Outpatient Hospital Services	$10 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$15 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$10 Copayment after deductible	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	$10 Copayment after deductible	No limit
Performed in Specialist Office	$10 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$10 Copayment after deductible	No limit
Home Infusion Therapy	$10 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$10 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$20 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$20 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$100 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$25 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$25 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$10 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$10 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$10 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$15 Copayment after deductible**	**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 and Other	**$20 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$25 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$25 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$25 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$25 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$25 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$10 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$10 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$10 Copayment after deductible**	**No limit**
Diabetic Education	**$10 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**5% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**5% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**5% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$100 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$10 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**5% Coinsurance after deductible**	
Prosthetic Devices		
External	**5% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**5% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$100 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$50 Copayment after deductible**	**No limit**
Bariatric Surgery	**$25 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$100 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$100 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$100 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$10 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$100 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$10 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$6 Copayment**	**No limit**
Tier 2	**$15 Copayment**	**No limit**
Tier 3	**$30 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$18 Copayment**	**No limit**
Tier 2	**$45 Copayment**	**No limit**
Tier 3	**$90 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$15 Copayment**	**No limit**
Tier 2	**$38 Copayment**	**No limit**
Tier 3	**$75 Copayment**	**No limit**
Enteral Formulas	**5% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$10 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$10 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$10 Copayment after deductible**	
Orthodontics	**$10 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$10 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**5% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**5% Coinsurance after deductible**	

Section II.C.ii – Silver 150-200% FPL CSR Standard Plan Benefit Description

Healthfirst Silver Leaf CSR 150-200 (and Silver Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$250**	
· **Family**	**$750**	
Out-of-Pocket Limit		
· **Individual**	**$2,000**	
· **Family**	**$4,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$15 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$35 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$35 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$35 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$75 Copayment after deductible**	**No limit**
Emergency Department	**$75 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$75 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$15 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$15 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$15 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment after deductible**	**No limit**
Chiropractic Services	**$35 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$15 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$15 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office	**$15 Copayment after deductible**	

Setting		
Performed as Outpatient Hospital Services	$15 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$15 Copayment after deductible	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	$15 Copayment after deductible	No limit
Performed in Specialist Office	$15 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$15 Copayment after deductible	No limit
Home Infusion Therapy	$15 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$15 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$35 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$35 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$250 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$75 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$75 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$15 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$15 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$25 Copayment after deductible**	**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 and Other	**$35 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$75 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$75 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$75 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$75 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$75 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$15 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$15 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$15 Copayment after deductible**	**No limit**
Diabetic Education	**$15 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**10% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**10% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**10% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$250 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$15 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**10% Coinsurance after deductible**	
Prosthetic Devices		
External	**10% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**10% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$250 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$75 Copayment after deductible**	**No limit**
Bariatric Surgery	**$75 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$250 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$250 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$250 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$15 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$250 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$15 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$9 Copayment**	**No limit**
Tier 2	**$20 Copayment**	**No limit**
Tier 3	**$40 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$27 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$23 Copayment**	**No limit**
Tier 2	**$50 Copayment**	**No limit**
Tier 3	**$100 Copayment**	**No limit**
Enteral Formulas	**10% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$15 Copayment after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$15 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$15 Copayment after deductible**	
Orthodontics	**$15 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$15 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**10% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**10% Coinsurance after deductible**	

Section II.C.iii – Silver 200-250% FPL CSR Standard Plan Benefit Description

Healthfirst Silver Leaf CSR 200-250 (and Silver Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$1,200**	
· **Family**	**$2,400**	
Out-of-Pocket Limit		
· **Individual**	**$5,200**	
· **Family**	**$10,400**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$30 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$50 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$50 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$50 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Chiropractic Services	$50 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$30 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$30 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$30 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment after deductible	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	$30 Copayment after deductible	No limit
Performed in Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Home Infusion Therapy	$30 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,500 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$50 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$30 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$30 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$30 Copayment after deductible**	**No limit**
Diabetic Education	**$30 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**25% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**25% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**25% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,500 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$30 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**25% Coinsurance after deductible**	
Prosthetic Devices		
External	**25% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**25% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,500 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,500 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**$1,500 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$30 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$30 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**25% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$30 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$30 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$30 Copayment after deductible**	
Orthodontics	**$30 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$30 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**25% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**25% Coinsurance after deductible**	

Section II.D – Bronze Standard Plan Benefit Description

Healthfirst Bronze Leaf (& Healthfirst Bronze Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$3,000**	
· **Family**	**$6,000**	
Out-of-Pocket Limit		
· **Individual**	**$6,350**	
· **Family**	**$12,700**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**50% Coinsurance after deductible**	**No limit**
Specialist Office Visits (or home visits)	**50% Coinsurance after deductible**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**50% Coinsurance after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**50% Coinsurance after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**50% Coinsurance after deductible**	**No limit**
Emergency Department	**50% Coinsurance after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**50% Coinsurance after deductible**	**No limit**
Anesthesia Services (all settings)	**50% Coinsurance after deductible**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Chiropractic Services	50% Coinsurance after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	50% Coinsurance after deductible	
Performed in a Freestanding Center or Specialist Office	50% Coinsurance after deductible	

Setting		
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	50% Coinsurance after deductible	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 after deductible	No limit
Performed in Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Home Infusion Therapy	50% Coinsurance after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	50% Coinsurance after deductible	No limit
Laboratory Procedures		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**50% Coinsurance after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**50% Coinsurance after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**50% Coinsurance after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**50% Coinsurance after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**50% Coinsurance after deductible**	**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 and Other	**50% Coinsurance after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**50% Coinsurance after deductible**	**No limit**
Inpatient Hospital Surgery	**50% Coinsurance after deductible**	**No limit**
Outpatient Hospital Surgery	**50% Coinsurance after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**50% Coinsurance after deductible**	**No limit**
Office Surgery	**50% Coinsurance after deductible**	**No limit**
Elective Termination of Pregnancy	**50% Coinsurance after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**50% Coinsurance after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**50% Coinsurance after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**50% Coinsurance after deductible**	**No limit**
Diabetic Education	**50% Coinsurance after deductible**	**No limit**
Durable Medical Equipment and Braces	**50% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**50% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**50% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**50% Coinsurance after deductible**	**210 Days per Plan Year**
Outpatient	**50% Coinsurance after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**50% Coinsurance after deductible**	
Prosthetic Devices		
External	**50% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**50% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**50% Coinsurance after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**50% Coinsurance after deductible**	**No limit**

Bariatric Surgery	**50% Coinsurance after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**50% Coinsurance after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**50% Coinsurance after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**50% Coinsurance after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**50% Coinsurance after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**50% Coinsurance after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**50% Coinsurance after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**
Up to a 90-day supply for Maintenance Drugs		

Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**50% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**50% Coinsurance after deductible**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**50% Coinsurance after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**50% Coinsurance after deductible**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**50% Coinsurance after deductible**	

Orthodontics	**50% Coinsurance after deductible**	
Pediatric Vision Care		
Exams	**50% Coinsurance after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**50% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**50% Coinsurance after deductible**	

Section II.E – Catastrophic Standard Plan Benefit Description

Healthfirst Green Leaf (& Healthfirst Green Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$6,600**	
· **Family**	**$13,200**	
Out-of-Pocket Limit		
· **Individual**	**$6,600**	
· **Family**	**$13,200**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**Covered in full after deductible**	**No limit**
Specialist Office Visits (or home visits)	**Covered in full after deductible**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full after deductible**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**Covered in full after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**Covered in full after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**Covered in full after deductible**	**No limit**
Emergency Department	**Covered in full after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**Covered in full after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full after deductible**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Covered in full after deductible**	**No limit**
Chemotherapy		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Chiropractic Services	**Covered in full after deductible**	**No limit**
Clinical Trials	**Covered in full after deductible**	
Diagnostic Testing		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**Covered in full after deductible**	
Performed in a Freestanding Center or Specialist Office Setting	**Covered in full after deductible**	
Performed as Outpatient	**Covered in full after deductible**	

Hospital Services		
Habilitation Services	**Covered in full after deductible**	**60 visits per condition, per lifetime combined therapies**
(Physical Therapy, Occupational Therapy or Speech Therapy)		
Home Health Care	**Covered in full after deductible**	**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	**Covered in full after deductible**	**No limit**
Performed in Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Home Infusion Therapy	**Covered in full after deductible**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**
Inpatient Hospital Services and Birthing Center	**Covered in full after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**

Physician Midwife Services for Delivery	**Covered in full after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**Covered in full after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**Covered in full after deductible**	**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 and Other	**Covered in full after deductible**	**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		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.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	Covered in full after deductible	No limit
Inpatient Hospital Surgery	Covered in full after deductible	No limit
Outpatient Hospital Surgery	Covered in full after deductible	No limit
Surgery Performed at an Ambulatory Surgical Center	Covered in full after deductible	No limit
Office Surgery	Covered in full after deductible	No limit
Elective Termination of Pregnancy	Covered in full after deductible	1 Treatment per Year; Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	Covered in full after deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full after deductible	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a	Covered in full after deductible	No limit

90-day supply)		
Diabetic Education	**Covered in full after deductible**	**No limit**
Durable Medical Equipment and Braces	**Covered in full after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**Covered in full after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**Covered in full after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**Covered in full after deductible**	**210 Days per Plan Year**
Outpatient	**Covered in full after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**Covered in full after deductible**	
Prosthetic Devices		
External	**Covered in full after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**Covered in full after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**Covered in full after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**Covered in full after deductible**	**No limit**
Bariatric Surgery	**Covered in full after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**Covered in full after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and	**Covered in full after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**

Occupational therapy)		
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**Covered in full after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**Covered in full after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**Covered in full after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**Covered in full after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**Covered in full after deductible**	**No limit**
Tier 2	**Covered in full after deductible**	**No limit**
Tier 3	**Covered in full after deductible**	**No limit**
Up to a 90-day supply for Maintenance Drugs		
Tier 1	**Covered in full after deductible**	**No limit**
Tier 2	**Covered in full after deductible**	**No limit**
Tier 3	**Covered in full after deductible**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		

Tier 1	**Covered in full after deductible**	**No limit**
Tier 2	**Covered in full after deductible**	**No limit**
Tier 3	**Covered in full after deductible**	**No limit**
Enteral Formulas	**Covered in full after deductible**	**No limit**
Off Label Cancer Drugs	**Covered in full after deductible**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**Covered in full after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**Covered in full after deductible**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**Covered in full after deductible**	
Orthodontics	**Covered in full after deductible**	
Pediatric Vision Care		
Exams	**Covered in full after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**Covered in full after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**

Contact Lenses	**Covered in full after deductible**	

Section II.F – Native American/Alaska Native CSR Standard Plan Benefit Description

Healthfirst Native American/Alaskan Native CSR Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$0**	
· **Family**	**$0**	
Out-of-Pocket Limit		
· **Individual**	**$0**	
· **Family**	**$0**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**Covered in full**	**No limit**
Specialist Office Visits (or home visits)	**Covered in full**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**Covered in full**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**Covered in full**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**Covered in full**	**No limit**
Emergency Department	**Covered in full**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**Covered in full**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Performed as Inpatient Hospital Services	**Covered in full**	**No limit**
Chemotherapy		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Chiropractic Services	**Covered in full**	**No limit**
Clinical Trials	**Covered in full**	
Diagnostic Testing		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**Covered in full**	
Performed in a Freestanding Center or Specialist Office Setting	**Covered in full**	
Performed as Outpatient	**Covered in full**	

Hospital Services		
Habilitation Services	**Covered in full**	**60 visits per condition, per lifetime combined therapies**
(Physical Therapy, Occupational Therapy or Speech Therapy)		
Home Health Care	**Covered in full**	**40 Visits per Plan Year**
Infertility Services	**Covered in full**	**• Member must be between ages of 21 and 44** **• Advanced infertility not covered**
Infusion Therapy		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Home Infusion Therapy	**Covered in full**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**
Inpatient Hospital Services and Birthing Center	**Covered in full**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**

Physician Midwife Services for Delivery	**Covered in full**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**Covered in full**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**Covered in full**	**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 and Other	**Covered in full**	**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		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.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	Covered in full	No limit
Inpatient Hospital Surgery	Covered in full	No limit
Outpatient Hospital Surgery	Covered in full	No limit
Surgery Performed at an Ambulatory Surgical Center	Covered in full	No limit
Office Surgery	Covered in full	No limit
Elective Termination of Pregnancy	Covered in full	1 Treatment per Year; Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	Covered in full	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	Covered in full	No limit

Diabetic Education	**Covered in full**	**No limit**
Durable Medical Equipment and Braces	**Covered in full**	**Coverage for standard equipment only.**
External Hearing Aids	**Covered in full**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**Covered in full**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**Covered in full**	**210 Days per Plan Year**
Outpatient	**Covered in full**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**Covered in full**	
Prosthetic Devices		
External	**Covered in full**	**One prosthetic device, per limb, per lifetime**
Internal	**Covered in full**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**Covered in full. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**Covered in full**	**No limit**
Bariatric Surgery	**Covered in full**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**Covered in full**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**Covered in full**	**60 Consecutive Days Per Condition, Per Lifetime**

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**Covered in full. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**Covered in full**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**Covered in full Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**Covered in full**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**
Tier 3	**Covered in full**	**No limit**
Up to a 90-day supply for Maintenance Drugs		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**
Tier 3	**Covered in full**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**

Tier 3	**Covered in full**	**No limit**
Enteral Formulas	**Covered in full**	**No limit**
Off Label Cancer Drugs	**Covered in full**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**Covered in full**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**Covered in full**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**Covered in full**	
Orthodontics	**Covered in full**	
Pediatric Vision Care		
Exams	**Covered in full**	**One Exam Per 12-Month Period**
Lenses and Frames	**Covered in full**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**Covered in full**	

Section II.G – Platinum Non-Standard Plan Benefit Description

Healthfirst Platinum Leaf Premier Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$0**	
Family	**$0**	
Out-of-Pocket Limit		
Individual	**$2,000**	
Family	**$4,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$15 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$35 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$35 Copayment**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$100 Copayment**	**No limit**
Emergency Department	**$100 Copayment** **Copayment / Coinsurance waived if Hospital admission**	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$35 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Chiropractic Services	$35 Copayment	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Specialist Office	$35 Copayment	No limit
Performed as Outpatient Hospital Services	$35 Copayment	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$15 Copayment	
Performed in a Freestanding Center or Specialist Office	$15 Copayment	

Setting		
Performed as Outpatient Hospital Services	$15 Copayment	
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 Procedures)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		
Performed in a PCP Office	$15 Copayment	No limit
Performed in Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Home Infusion Therapy	$15 Copayment	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$35 Copayment	No limit
Performed as Outpatient Hospital Services	$35 Copayment	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$500 Copayment per admission**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$15 Copayment**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$35 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$15 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment**	**No limit**
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 and 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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
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 and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$15 Copayment**	**No limit**
Diabetic Education	**$15 Copayment**	**No limit**
Durable Medical Equipment and Braces	**10% Coinsurance**	**Coverage for standard equipment only.**
External Hearing Aids	**10% Coinsurance**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**10% Coinsurance**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$500 Copayment per admission**	**210 Days per Plan Year**
Outpatient	**$15 Copayment**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**10% Coinsurance**	
Prosthetic Devices		
External	**10% Coinsurance**	**One prosthetic device, per limb, per lifetime**
Internal	**10% Coinsurance**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**$100 Copayment**	**No limit**

Bariatric Surgery	**$100 Copayment**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$500 Copayment per admission**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$500 Copayment per admission**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
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 and Intensive Outpatient Program Services)	**$15 Copayment**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions**	**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	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$30 Copayment**	**No limit**
Tier 3	**$60 Copayment**	**No limit**
Up to a 90-day supply for Maintenance Drugs		

Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$90 Copayment**	**No limit**
Tier 3	**$180 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$75 Copayment**	**No limit**
Tier 3	**$150 Copayment**	**No limit**
Enteral Formulas	**10% Coinsurance**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$15 Copayment**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$15 Copayment**	
Major Dental (Endodontics, Periodontics and	**$15 Copayment**	

Prosthodontics)		
Orthodontics	**$15 Copayment**	
Vision Care		
Exams	**$15 Copayment**	**One Exam Per 12-Month Period**
Lenses and Frames	**10% Coinsurance**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**10% Coinsurance**	

Section II.H – Gold Non-Standard Plan Benefit Description

Healthfirst Gold Leaf Premier Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$600**	
Family	**$1,200**	
Out-of-Pocket Limit		
Individual	**$4,000**	
Family	**$8,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$25 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$40 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**

Vasectomy	**$40 Copayment after deductible**	**No limit**
Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$40 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**

Anesthesia Services (all settings)	**Covered in full**	**No limit**
Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Chiropractic Services	**$40 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$25 Copayment after deductible**	

Performed in a Freestanding Center or Specialist Office Setting	**$25 Copayment after deductible**	
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	
Habilitation Services **(Physical Therapy, Occupational Therapy or Speech Therapy)**	**$30 Copayment after deductible**	**60 visits per condition, per lifetime combined therapies**
Home Health Care	**$25 Copayment after deductible**	**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	**$25 Copayment after deductible**	**No limit**
Performed in Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Home Infusion Therapy	**$25 Copayment after deductible**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**

Inpatient Hospital Services and Birthing Center	**$1,000 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$40 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$25 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$25 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$25 Copayment after deductible**	**No limit**
Diabetic Education	**$25 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**20% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**20% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**20% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,000 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$25 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**20% Coinsurance after deductible**	
Prosthetic Devices		
External	**20% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**20% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,000 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,000 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,000 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$25 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$25 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**20% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$25 Copayment after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$25 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$25 Copayment after deductible**	
Orthodontics	**$25 Copayment after deductible**	
Vision Care		
Exams	**$25 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**20% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**20% Coinsurance after deductible**	

Section II.I – Silver Non-Standard Plan Benefit Description

Healthfirst Silver Leaf Premier Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$2,000**	
· **Family**	**$4,000**	
Out-of-Pocket Limit		
· **Individual**	**$5,500**	
· **Family**	**$11,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$30 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$50 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$50 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$50 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Chiropractic Services	$50 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$30 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$30 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$30 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment after deductible	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	$30 Copayment after deductible	No limit
Performed in Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Home Infusion Therapy	$30 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,500 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$50 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$30 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$30 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$30 Copayment after deductible**	**No limit**
Diabetic Education	**$30 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**30% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**30% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**30% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,500 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$30 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**30% Coinsurance after deductible**	
Prosthetic Devices		
External	**30% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**30% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,500 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,500 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,500 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$30 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$30 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**30% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$30 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$30 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$30 Copayment after deductible**	
Orthodontics	**$30 Copayment after deductible**	
Vision Care		
Exams	**$30 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**30% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**30% Coinsurance after deductible**	

Section II.J – Silver 100-150% FPL Non-Standard Plan Benefit Description

Healthfirst Silver Leaf Premier CSR 100-150 Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$0**	
· **Family**	**$0**	
Out-of-Pocket Limit		
· **Individual**	**$1,000**	
· **Family**	**$2,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$10 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$20 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$20 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$20 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$50 Copayment after deductible**	**No limit**
Emergency Department	**$50 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$25 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$10 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$10 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$10 Copayment after deductible	No limit
Performed in a Specialist Office	$10 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$10 Copayment after deductible	No limit
Chiropractic Services	$20 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$10 Copayment after deductible	No limit
Performed in a Specialist Office	$20 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$20 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$10 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$10 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$10 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$15 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$10 Copayment after deductible	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	$10 Copayment after deductible	No limit
Performed in Specialist Office	$10 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$10 Copayment after deductible	No limit
Home Infusion Therapy	$10 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$10 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$20 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$20 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$100 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$25 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$25 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$10 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$10 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$10 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$15 Copayment after deductible**	**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 and Other	**$20 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$25 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$25 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$25 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$25 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$25 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$10 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$10 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$10 Copayment after deductible**	**No limit**
Diabetic Education	**$10 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**5% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**5% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**5% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$100 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$10 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**5% Coinsurance after deductible**	
Prosthetic Devices		
External	**5% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**5% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$100 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$50 Copayment after deductible**	**No limit**
Bariatric Surgery	**$25 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$100 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$100 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$100 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$10 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$100 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$10 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$6 Copayment**	**No limit**
Tier 2	**$15 Copayment**	**No limit**
Tier 3	**$30 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$18 Copayment**	**No limit**
Tier 2	**$45 Copayment**	**No limit**
Tier 3	**$90 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$15 Copayment**	**No limit**
Tier 2	**$38 Copayment**	**No limit**
Tier 3	**$75 Copayment**	**No limit**
Enteral Formulas	**5% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$10 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$10 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$10 Copayment after deductible**	
Orthodontics	**$10 Copayment after deductible**	
Vision Care		
Exams	**$10 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**5% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**5% Coinsurance after deductible**	

Section II.K – Silver 150-200% FPL Non-Standard Plan Benefit Description

Healthfirst Silver Leaf Premier CSR 150-200 Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$250**	
· **Family**	**$750**	
Out-of-Pocket Limit		
· **Individual**	**$2,000**	
· **Family**	**$4,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$15 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$35 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$35 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$35 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$75 Copayment after deductible**	**No limit**
Emergency Department	**$75 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$75 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$15 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$15 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$15 Copayment after deductible	No limit
Performed in a Specialist Office	$15 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$15 Copayment after deductible	No limit
Chiropractic Services	$35 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$15 Copayment after deductible	No limit
Performed in a Specialist Office	$35 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$35 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$15 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$15 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$15 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$15 Copayment after deductible	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	$15 Copayment after deductible	No limit
Performed in Specialist Office	$15 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$15 Copayment after deductible	No limit
Home Infusion Therapy	$15 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$15 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$35 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$35 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$250 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$75 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$75 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$15 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$15 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$25 Copayment after deductible**	**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 and Other	**$35 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$75 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$75 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$75 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$75 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$75 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$15 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$15 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$15 Copayment after deductible**	**No limit**
Diabetic Education	**$15 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**10% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**10% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**10% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$250 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$15 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**10% Coinsurance after deductible**	
Prosthetic Devices		
External	**10% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**10% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$250 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$75 Copayment after deductible**	**No limit**
Bariatric Surgery	**$75 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$250 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$250 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$250 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$15 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$250 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$15 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$9 Copayment**	**No limit**
Tier 2	**$20 Copayment**	**No limit**
Tier 3	**$40 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$27 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$23 Copayment**	**No limit**
Tier 2	**$50 Copayment**	**No limit**
Tier 3	**$100 Copayment**	**No limit**
Enteral Formulas	**10% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$15 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$15 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$15 Copayment after deductible**	
Orthodontics	**$15 Copayment after deductible**	
Vision Care		
Exams	**$15 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**10% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**10% Coinsurance after deductible**	

Section II.L – Silver 200-250% FPL Non-Standard Plan Benefit Description

Healthfirst Silver Leaf CSR 200-250 Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$1,200**	
· **Family**	**$2,400**	
Out-of-Pocket Limit		
· **Individual**	**$5,200**	
· **Family**	**$10,400**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$30 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$50 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$50 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$50 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Chiropractic Services	$50 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$30 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$30 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$30 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment after deductible	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	$30 Copayment after deductible	No limit
Performed in Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Home Infusion Therapy	$30 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,500 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$50 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$30 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$30 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$30 Copayment after deductible**	**No limit**
Diabetic Education	**$30 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**25% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**25% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**25% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,500 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$30 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**25% Coinsurance after deductible**	
Prosthetic Devices		
External	**25% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**25% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,500 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,500 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**$1,500 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$30 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$30 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**25% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$30 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$30 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$30 Copayment after deductible**	
Orthodontics	**$30 Copayment after deductible**	
Vision Care		
Exams	**$30 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**25% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**25% Coinsurance after deductible**	

Section II.M – Bronze Non-Standard Plan Benefit Description

Healthfirst Bronze Leaf Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$3,000**	
· **Family**	**$6,000**	
Out-of-Pocket Limit		
· **Individual**	**$6,350**	
· **Family**	**$12,700**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**50% Coinsurance after deductible**	**No limit**
Specialist Office Visits (or home visits)	**50% Coinsurance after deductible**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**50% Coinsurance after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**50% Coinsurance after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**50% Coinsurance after deductible**	**No limit**
Emergency Department	**50% Coinsurance after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**50% Coinsurance after deductible**	**No limit**
Anesthesia Services (all settings)	**50% Coinsurance after deductible**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Chiropractic Services	50% Coinsurance after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	50% Coinsurance after deductible	
Performed in a Freestanding Center or Specialist Office	50% Coinsurance after deductible	

Setting		
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	50% Coinsurance after deductible	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 after deductible	No limit
Performed in Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Home Infusion Therapy	50% Coinsurance after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	50% Coinsurance after deductible	No limit
Laboratory Procedures		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**50% Coinsurance after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**50% Coinsurance after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**50% Coinsurance after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**50% Coinsurance after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**50% Coinsurance after deductible**	**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 and Other	**50% Coinsurance after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**50% Coinsurance after deductible**	**No limit**
Inpatient Hospital Surgery	**50% Coinsurance after deductible**	**No limit**
Outpatient Hospital Surgery	**50% Coinsurance after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**50% Coinsurance after deductible**	**No limit**
Office Surgery	**50% Coinsurance after deductible**	**No limit**
Elective Termination of Pregnancy	**50% Coinsurance after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**50% Coinsurance after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**50% Coinsurance after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**50% Coinsurance after deductible**	**No limit**
Diabetic Education	**50% Coinsurance after deductible**	**No limit**
Durable Medical Equipment and Braces	**50% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**50% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**50% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**50% Coinsurance after deductible**	**210 Days per Plan Year**
Outpatient	**50% Coinsurance after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**50% Coinsurance after deductible**	
Prosthetic Devices		
External	**50% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**50% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**50% Coinsurance after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**50% Coinsurance after deductible**	**No limit**

Bariatric Surgery	**50% Coinsurance after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**50% Coinsurance after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**50% Coinsurance after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**50% Coinsurance after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**50% Coinsurance after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**50% Coinsurance after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**50% Coinsurance after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**
Up to a 90-day supply for Maintenance Drugs		

Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**50% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**50% Coinsurance after deductible**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**50% Coinsurance after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**50% Coinsurance after deductible**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**50% Coinsurance after deductible**	

Orthodontics	**50% Coinsurance after deductible**	
Vision Care		
Exams	**50% Coinsurance after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**50% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**50% Coinsurance after deductible**	

Section II.N – Native American/Alaska Native Non-Standard Plan Benefit Description

Healthfirst Native American/Alaskan Native Premier CSR Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$0**	
· **Family**	**$0**	
Out-of-Pocket Limit		
· **Individual**	**$0**	
· **Family**	**$0**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**Covered in full**	**No limit**
Specialist Office Visits (or home visits)	**Covered in full**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**Covered in full**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**Covered in full**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**Covered in full**	**No limit**
Emergency Department	**Covered in full**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**Covered in full**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Performed as Inpatient Hospital Services	**Covered in full**	**No limit**
Chemotherapy		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Chiropractic Services	**Covered in full**	**No limit**
Clinical Trials	**Covered in full**	
Diagnostic Testing		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**Covered in full**	
Performed in a Freestanding Center or Specialist Office Setting	**Covered in full**	
Performed as Outpatient	**Covered in full**	

Hospital Services		
Habilitation Services	**Covered in full**	**60 visits per condition, per lifetime combined therapies**
(Physical Therapy, Occupational Therapy or Speech Therapy)		
Home Health Care	**Covered in full**	**40 Visits per Plan Year**
Infertility Services	**Covered in full**	**• Member must be between ages of 21 and 44** **• Advanced infertility not covered**
Infusion Therapy		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Home Infusion Therapy	**Covered in full**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**
Inpatient Hospital Services and Birthing Center	**Covered in full**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**

Physician Midwife Services for Delivery	**Covered in full**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**Covered in full**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**Covered in full**	**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 and Other	**Covered in full**	**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		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.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	Covered in full	No limit
Inpatient Hospital Surgery	Covered in full	No limit
Outpatient Hospital Surgery	Covered in full	No limit
Surgery Performed at an Ambulatory Surgical Center	Covered in full	No limit
Office Surgery	Covered in full	No limit
Elective Termination of Pregnancy	Covered in full	1 Treatment per Year; Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	Covered in full	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	Covered in full	No limit

Diabetic Education	**Covered in full**	**No limit**
Durable Medical Equipment and Braces	**Covered in full**	**Coverage for standard equipment only.**
External Hearing Aids	**Covered in full**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**Covered in full**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**Covered in full**	**210 Days per Plan Year**
Outpatient	**Covered in full**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**Covered in full**	
Prosthetic Devices		
External	**Covered in full**	**One prosthetic device, per limb, per lifetime**
Internal	**Covered in full**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**Covered in full. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**Covered in full**	**No limit**
Bariatric Surgery	**Covered in full**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**Covered in full**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**Covered in full**	**60 Consecutive Days Per Condition, Per Lifetime**

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**Covered in full. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**Covered in full**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**Covered in full Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**Covered in full**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**
Tier 3	**Covered in full**	**No limit**
Up to a 90-day supply for Maintenance Drugs		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**
Tier 3	**Covered in full**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**

Tier 3	**Covered in full**	**No limit**
Enteral Formulas	**Covered in full**	**No limit**
Off Label Cancer Drugs	**Covered in full**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**Covered in full**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**Covered in full**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**Covered in full**	
Orthodontics	**Covered in full**	
Pediatric Vision Care		
Exams	**Covered in full**	**One Exam Per 12-Month Period**
Lenses and Frames	**Covered in full**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**Covered in full**	

SECTION III – Underwriting Guidelines

Healthfirst PHSP, Inc.'s (Healthfirst) individual Direct Pay products are available for enrollment by eligible individuals and families. Coverage is intended for persons of majority age (and those younger than the majority age in the case of Direct Pay child-only plans) but younger than 65 years and not eligible for Medicare.

All Direct Pay products are made available in accordance with applicable state and federal laws and regulations, including New York's community rating and guaranteed issue laws. Enrollment into Healthfirst's Direct Pay products, both on- and off-Exchange, is limited to annual Open Enrollment periods and Special Enrollment periods.

A. ELIGIBILITY REQUIREMENTS:

- Applicants must live or reside within Healthfirst's service area, which, for the 2015 coverage year, includes New York, Richmond, Queens, Kings, Bronx, Nassau and Suffolk Counties.

- The following types of dependents are eligible to enroll in the policyholder's coverage: legal spouses; domestic partners; unmarried dependent children; natural children; legally adopted children; legal wards; step children; unmarried disabled/mentally retarded child; and children for whom the policyholder is the proposed adoptive parent without regard to financial dependence, residency with the policyholder, student status or employment.

- Foster Children and grandchildren are ineligible for dependent coverage.

- Individuals enrolled under group or another Direct Pay plan which would duplicate any benefits covered under Healthfirst's policy, are ineligible.

B. COVERAGE TERMINATION

Direct Pay coverage may be terminated under a variety of circumstances, as described in the subscriber contract. These include but are not limited to:

- Failure to pay outstanding premium amounts by the end of the grace period.
- The policyholder no longer lives or resides in Healthfirst's service area.
- Upon the policyholder's death. Surviving dependents will be terminated as of the last day of the month for which the premium has been paid.
- For spouses, on the date of divorce.
- For children, at the end of the month in which the child turns 26 years of age (unless an Age 29 Rider is selected).
- Upon the receipt of a written termination request which has been delivered at least 30 days prior to the request termination date.
- No longer meeting the eligibility requirements.
- The performance of an act that constitutes fraud or the intentional misrepresentation of material fact in writing on the policyholder's enrollment application.

Supporting Document Schedules

Satisfied - Item:	Actuarial Value Calculations
Comments:	The AV calculations for the standard plans included in this filing also apply to the non-standard plans present in this filing.
Attachment(s):	AV PHSP.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 13-Narrative Summary and Numerical Summary
Comments:	
Attachment(s):	Exhibit 13 - HF PHSP Ind OnExchange 2015 FINAL.pdf Exhibit 13 - HF PHSP Ind OnExchange 2015 FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 14A-Indiv Requested Percentage Changes
Comments:	
Attachment(s):	Exhibit 14A - HF PHSP Ind OnExchange 2015 FINAL.pdf Exhibit 14A - HF PHSP Ind OnExchange 2015 FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 15A-Indiv Distribution by Rate Adj Percentages
Comments:	
Attachment(s):	Exhibit 15A - HF PHSP Ind OnExchange 2015 FINAL.pdf Exhibit 15A - HF PHSP Ind OnExchange 2015 FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 18-Index Rate Plan-Design Development
Comments:	
Attachment(s):	Exhibit 18 - HF PHSP Ind OnExchange 2015 FINAL.pdf Exhibit 18 - HF PHSP Ind OnExchange 2015 FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 19-Claim Trend, Admin Expenses & Profit
Comments:	

State: New York **Filing Company:** Healthfirst PHSP, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Healthfirst PHSP On-Exchange Individual 2015 Rate Filing
Project Name/Number: /

Attachment(s):	Exhibit 19 - HF PHSP Ind OnExchange 2015 FINAL.pdf Exhibit 19 - HF PHSP Ind OnExchange 2015 FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 20-HIOS ID Mapping
Comments:	
Attachment(s):	Exhibit 20 - HF PHSP Ind OnExchange 2015 FINAL.pdf Exhibit 20 - HF PHSP Ind OnExchange 2015 FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 23-Requested 2015 Premium Rates
Comments:	
Attachment(s):	Exhibit 23 - HF PHSP Ind OnExchange 2015 FINAL.xlsx Exhibit 23 - HF PHSP Ind OnExchange 2015 FINAL.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Initial Notice of Proposed Rate Adjustment
Comments:	
Attachment(s):	Initial rate adjustment notice (Individual On-Exchange Policyholder) for submission - Healthfirst PHSP Inc.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Documents for Web Posting
Comments:	
Attachment(s):	Actuarial Memorandum - PHSP On-Exchange - to DFS_Redacted.pdf Actuarial Memorandum - PHSP On-Exchange - to HHS_REDACTED.pdf Healthfirst PHSP_Rate Manual_QHPs On Exchange for 2015 (new) 2_Redacted.pdf Exhibit 11 - HF PHSP Individual OnExchange_REDACTED v2.pdf Healthfirst PHSP Ind Readability Certification Letter_FINAL 2015_REDACTED.pdf HF PHSP Ind OnExchange Readability Certification FINAL 2015 v2_Redacted.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	

State: *New York* **Filing Company:** *Healthfirst PHSP, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Healthfirst PHSP On-Exchange Individual 2015 Rate Filing*
Project Name/Number: */*

Attachment(s):	HF PHSP URRT 2015 FINAL.pdf HF PHSP URRT 2015 FINAL.xlsm
Item Status:	
Status Date:	

Attachment Exhibit 13 - HF PHSP Ind OnExchange 2015 FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 14A - HF PHSP Ind OnExchange 2015 FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 15A - HF PHSP Ind OnExchange 2015 FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 18 - HF PHSP Ind OnExchange 2015 FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 19 - HF PHSP Ind OnExchange 2015 FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 20 - HF PHSP Ind OnExchange 2015 FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 23 - HF PHSP Ind OnExchange 2015 FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment HF PHSP URRT 2015 FINAL.xlsm is not a PDF document and cannot be reproduced here.

Appendix D

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑		
Specialist Visit	☐	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$35.00	☑	☑		
Skilled Nursing Facility	☐	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	96.28%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	93.75%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.12%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$5,500.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.69%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,200.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.99%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$250.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$75.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑		
Skilled Nursing Facility	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.83%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.66%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$1,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$20.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$20.00	☑	☑		
Skilled Nursing Facility	☐	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98.48%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.76%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$6.00	☑	☑		
Preferred Brand Drugs	☐	☐		$15.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$30.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.43%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.99%
Metal Tier:	Bronze

Catastrophic Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,600.00			
Coinsurance (%, Insurer's Cost Share)			100%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑	
# Visits (1-10):		3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.4%
Metal Tier:	Bronze

NARRATIVE SUMMARY

Community-Rated Individual Commercial Comprehensive Premium Rate Filings
Plan Year 2015

Healthfirst PHSP, Inc. (Healthfirst) has submitted to the New York Department of Financial Services (DFS) an application to adjust premium rates for direct pay individual market health insurance coverage effective in 2015. Healthfirst has requested a decrease in premium rates for plans offered in 2015. The Department of Financial Services is reviewing Healthfirst's requested premium rate decrease and will determine if the rates are appropriate based on the available evidence.

The requested rate adjustments will affect all currently enrolled individual market subscribers renewing coverage for the 2015 calendar year as well as new individual policies issued during the 2015 calendar year. Final rate adjustments approved by DFS will be effective January 1, 2015. The rates are guaranteed for a 12-month period ending December 31, 2015 and are subject to New York's community rating and guarantee issue laws. Subscribers' rates will vary according to the benefit plan in which they enroll, as well as the census/family tier they select.

As of the date of the submission of this Narrative Summary, approximately 7,508 covered lives (i.e., subscribers and their covered dependents) are estimated to be affected by the rate adjustment.

A Description of Your Premium Rate

Your health insurance premium rate has two main components. One is the costs of paying for medical care and the other is Healthfirst's administrative costs.

1. **Medical care costs.** The largest portion of your health insurance premium rate goes toward paying for the costs of the medical claims submitted by you and other members enrolled in Healthfirst's individual market plans. Under New York law, at least 82 percent of the premium Healthfirst's members pay must be put toward paying for the costs of medical claims. More than 82 percent of Healthfirst's premium dollars is used for paying medical expenses.

2. **Administrative costs.** Administrative expenses include a wide range of services and functions, such as processing claims and upgrading technology to keep pace with the rapidly changing health care sector. It also accounts for an array of member-centric expenses such as conducting medical necessity reviews, managing members' complex and chronic conditions, maintaining a robust provider network, and partnering with the community on health education initiatives.

Healthfirst takes a meaningful and evidence-based approach to determining how much of a rate adjustment to request from DFS.

Your Rate Adjustment Explained

Healthfirst is applying for a rate adjustment to account for marketplace trends and to reflect actual and anticipated claims costs. While several market forces continue to drive health care costs higher more generally, Healthfirst continues to strengthen the effectiveness of its care management and quality improvement programs and robust network.

This requested rate change is based primarily only on preliminary data and information related to what the medical utilization, cost trends, and other data elements will be at year's end. The demographic make-up of Healthfirst's Qualified Health Plan (QHP) membership, for instance, is currently different than was expected. Based on these factors, information provided by New York State, and Healthfirst's projections, the membership's average demand for medical services may diminish in 2015. Healthfirst's premium rates must therefore be adjusted to accurately reflect these changing factors.

The premium rate decreases Healthfirst is requesting are summarized in the table below.

Plan Name	Requested Decrease
Healthfirst Platinum Leaf	9.6%
Healthfirst Gold Leaf	9.6%
Healthfirst Silver Leaf	9.8%
Healthfirst Bronze Leaf	9.8%
Healthfirst Green Leaf	33.9%

Final Rate Adjustment

The final rate adjustment that Healthfirst members experience may differ than what DFS eventually approves. Healthfirst will notify its currently enrolled members approximately 60 days prior to the new rate taking effect.

EXHIBIT 13: NARRATIVE SUMMARY AND NUMERICAL SUMMARY

Company	Healthfirst PHSP, Inc.
NAIC Code:	15071
SERFF Trac	HLFT-129571607
Market Segment:	Individuals On Exchange

1) Please complete this Narrative Summary and Numerical Summary for each market segment for which you are submitted a rate filing.
2) The Narrative Summary must be in plain English and should clearly and simply explain the reasons for the requested rate adjustment.
3) The purpose of the Narrative Summary is to provide a written explanation to the company's policyholders to help them understand the reasons why a rate increase is needed.
4) The purpose of the Numerical Summary is to provide a clear and simple overview of the requested rate adjustment.
5) These Summaries will be public documents and will be posted on DFS's website and furnished by DFS to the public upon request.
6) The company should submit the these Summaries to DFS ten (10) days before submitting a rate adjustment filing.
7) A draft of these Summaries and of the Initial Notice must be included in a "Prior Approval Prefiling" submitted to DFS via SERFF.
8) Once reviewed by DFS, these Summaries must be posted to a location on its website that is publicly available and accessible without the need for a user ID/password.
9) Links should be provided on key pages of the company's website so that the information may be easily located.
10) Any change(s) made to the Narrative Summary/Numerical Summary subsequent to the posting must be submitted to DFS with the specific change(s) identified.
11) This exhibit must be submitted as an Excel file and as a PDF file.

A. Average 2014 and 2015 Premium Rates:

1) Average Monthly Premium Rates for Individual Only on Individual Plans and First Quarter Rates for Employee Only on Small Group Plans.
2) Premium Rates are Average Arithmetic Premium Rates for All Plans Combined and for all Regions combined.
3) Premium Rates are with Through Age 29, with Domestic Partner and with Family Planning Coverage.
4) Premium Rates for 2015 should be Consistent with the Premium Rates reflected in Exhibit 23.
5) Premium Rates for 2014 should be on a Consistent Basis as the Premium Rates for 2015.

	Platinum	Gold	Silver	Bronze	Catastrophic
2014 Premium Rates	$616.59	$520.36	$445.16	$380.05	$317.92
2015 Premium Rates	$556.88	$469.90	$401.45	$342.50	$210.03

B. Weighted Average Annual Percentage Requested Adjustments [Per Exhibit 14A for Individual Plans and Exhibit 14B for Small Group Plans]*:

	2014 to 2015
Requested Rate Adjustment	-9.8%

C. Weighted Average Annual Percentage Requested Adjustments for each of the Past Three Years [Per Exhibits 4A-4D] [If Applicable]*:

	2011 to 2012	2012 to 2013	2013 to 2014
Average Rate Adjustment	NA	NA	NA

D. Average Medical Loss Ratios [MLR] for All Policies Impacted [Ratios of Incurred Claims to Earned Premiums] [If Applicable]*:

	2011	2012	2013
MLR	NA	NA	NA

E. Claim Trend Rates and Average Ratios to Earned Premiums [Per Exhibit 19 for 2014-15 and Comparable Exhibits for 2013] [If Applicable]*:

	2013	2014	2015
Annual Claim Trend Rates	NA	8.0%	7.6%
Expense Ratios	NA	14.2%	13.8%
Pre Tax Profit Ratios	NA	2.0%	2.0%

* If product was not offered in a particular year, indicate "N/A" in the applicable box.

EXHIBIT 14A

EXHIBIT 14 - PART A: SUMMARY OF REQUESTED PERCENTAGE CHANGES TO EXISTING RATES

-- for Individual Medical Plans

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Tracking #: HLFT-129571607
Market Segment: Individuals On Exchange

1) Use this Exhibit for Individual Medical Plans. Individual market ACA compliant plans must use non-rolling rates where rates change each January 1.
2) The format of this exhibit is discussed below. Add more rows as needed. Only use the first tab for data entry.
3) Market segment refers to Individual plans.
4) The requested percentage rate change reflects the expected change in premium rates that would apply to the contract holder on that contract holder's next rate change date for each contract holder within the indicated combination of metal level, rating region, and product name.
5) The product name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/metal level when communicating with DFS). A separate row is to be used for each combination of metal level, rating region and product name.
6) If the percentage changes (lowest and highest and weighted average) are identical for all the rating regions, then separate rows by rating region need not be used, and "All Regions" can be shown in the Rating Region column. If the rate change range information differs by rating region, then separate rows need to be used for each rating region the insurer uses. Rating region names used on this exhibit are to use the standard rating region names developed by DFS (e.g., Albany Area, Buffalo Area, etc.).
7) The "requested rate change" includes the impact of any riders (such as: age 29, domestic partner, family planning, pediatric dental, etc.).
8) Lowest should be the smallest percentage change that could affect any contract holder due to the submitted rate filing with that metal level, and rating region, including any applicable riders. This includes benefit designs included in this rate filing which have no actual members.
9) Highest should be the largest percentage change that could affect any contract holder due to the submitted rate filing with that metal level, and rating region, including any applicable riders. This includes plan designs included in this rate filing which have no actual members.
10) The weighted average percentage should be developed based on annualized premium volume or membership for that metal level, and rating region, including any applicable riders.
11) This exhibit must be submitted as an Excel file and as a PDF file.

Individual Medical Plan Products

Market Segment	Effective Date of New Rate	Metal Level (or Catastrophic)	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Individual	01/01/15	Platinum	99 - All Regions	Healthfirst Platinum Leaf	Platinum Leaf	-9.7%	-9.7%	-9.7%
Individual	01/01/15	Gold	99 - All Regions	Healthfirst Gold Leaf	Gold Leaf	-9.7%	-9.7%	-9.7%
Individual	01/01/15	Silver	99 - All Regions	Healthfirst Silver Leaf	Silver Leaf	-9.8%	-9.8%	-9.8%
Individual	01/01/15	Bronze	99 - All Regions	Healthfirst Bronze Leaf	Bronze Leaf	-9.9%	-9.9%	-9.9%
Individual	01/01/15	Catastrophic	99 - All Regions	Healthfirst Green Leaf	Green Leaf	-33.9%	-33.9%	-33.9%
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							

EXHIBIT 14A

Individual Medical Plan Products

Market Segment	Effective Date of New Rate	Metal Level (or Catastrophic)	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							
Individual	01/01/15							

EXHIBIT 15 - PART A: DISTRIBUTION OF CONTRACTS BY REQUESTED PERCENT ADJUSTMENTS FOR INDIVIDUAL PRODUCTS

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Tracking #: HLFT-129571607
Market Segment: Individuals On Exchange

Instructions:

1) The percentage rate change reflects the impact of all riders that apply to the contracts. The percentage rate change reflects the expected change in premium that would apply to the contract holder on that contract holder's next rate change date.
2) The distribution is by number of members or number of contracts. The Company should fill in the appropriate column below (members or contracts) and replace the mm/dd/yy placeholder with the applicable as of date.
3) The Weighted Average Percentage change should be developed based on the distribution of annualized premiums for that Market Segment/Metal Level/Rating Region and for the market segment in total.
4) Market segment refers to Individual market segment.
5) Rating region refers to the standard rating regions applicable to this filing. If the percentage change for each plan design does not vary by region, then "All Regions" can be used in the rating region column; otherwise indicate the applicable rating region.
6) Under each market segment, the table should provide the distribution by metal level (platinum, gold, silver, bronze, catastrophic).
7) Provide the distribution of contracts or members affected by proposed rate change for all contracts by metal level/rating region.
8) Edit the worksheet to add more rows as needed. Only use the first tab for data entry.
9) Enter the sum of the counts in the various columns, and the market segment weighted avg change %.
10) This exhibit must be submitted as an Excel file and a PDF file.

Distribution by Requested Rate Adjustment

Market Segment	Effective Date	Metal Level (or Catastrophic)	Rating Region	Weighted Avg Change %	Annualized Premiums as of	Total # of Members as of	Total # of Contracts as of	Number of (*) with Requested Percentage Rate Change at Renewal										
					6/1/2014			Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher
Individual	1/1/2015	Platinum	99 - All Regions	-9.7%	2,193,838	434	344	434	0	0	0	0	0	0	0	0	0	0
Individual	1/1/2015	Gold	99 - All Regions	-9.7%	1,342,812	313	242	313	0	0	0	0	0	0	0	0	0	0
Individual	1/1/2015	Silver	99 - All Regions	-9.8%	19,407,709	5,781	4,557	5,781	0	0	0	0	0	0	0	0	0	0
Individual	1/1/2015	Bronze	99 - All Regions	-9.9%	2,218,211	878	741	878	0	0	0	0	0	0	0	0	0	0
Individual	1/1/2015	Catastrophic	99 - All Regions	-33.9%	10,156	6	6	6	0	0	0	0	0	0	0	0	0	0
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Individual	1/1/2015																	
Market Segment Total:				-9.8%	25,172,725	7,412	5,890	7,412	0	0	0	0	0	0	0	0	0	0

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Number: HLFT-129571607
Market Segment : Individuals On Exchange

Separate column for each plan design (on or off Exchange)

Line #	General							
1	Product*	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
2	Product ID*	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.620	0.620	0.707	0.707	0.707	0.791
5	AV Pricing Value (total, risk pool experience based)*	0.707	0.714	0.707	0.829	0.837	0.829	0.970
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Bronze with Dependent Age 26 & Dental, On-Exchange	Bronze with Dependent Age 29 & Dental, On-Exchange	Child-Only Bronze with Dental, On-Exchange	Silver with Dependent Age 26 & Dental, On-Exchange	Silver with Dependent Age 29 & Dental, On-Exchange	Child-Only Silver with Dental, On-Exchange	Gold with Dependent Age 26 & Dental, On-Exchange
8	HIOS Plan ID*	91237NY0020001	91237NY0020002	91237NY0020019	91237NY0020005	91237NY0020006	91237NY0020021	91237NY0020009
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate							
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	$226,797,009						
10B	Member-Months for Latest Experience Period	871467.773						
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	260.25						
11	Average Pricing Actuarial Value reflected in experience period	1.126						
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate	
13	Impact of adjusting experience period data to EHB benefit level	1.064
14	Market wide adjustment for changes in provider network **	0.991
15	Market wide adjustment for fee schedule changes **	1.384
16	Market wide adjustment for utilization management changes **	1.000
17	Market wide adustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics ** **	1.150
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Number: HLFT-129571607
Market Segment : Individuals On Exchange

Separate column for each plan design (on or off Exchange)

Line #	General							
1	Product*	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
2	Product ID*	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.620	0.620	0.707	0.707	0.707	0.791
5	AV Pricing Value (total, risk pool experience based)*	0.707	0.714	0.707	0.829	0.837	0.829	0.970
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000						
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	0.995						
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.943						
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000						
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.157						
25	Other 1 (specify)	1.056						
26	Other 2 (specify)	1.000						
27	Other 3 (specify)	1.000						
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
29	Pricing actuarial value (without induced demand factor) #	0.620	0.620	0.620	0.707	0.707	0.707	0.791
30	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.030	1.030	1.030	1.080
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.166	1.166	1.166	1.164	1.164	1.164	1.162
37	Profit/Contribution to surplus margins	1.020	1.020	1.020	1.020	1.020	1.020	1.020
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Number: HLFT-129571607
Market Segment : Individuals On Exchange

Separate column for each plan design (on or off Exchange)

Line #	General							
1	Product*	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
2	Product ID*	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.620	0.620	0.707	0.707	0.707	0.791
5	AV Pricing Value (total, risk pool experience based)*	0.707	0.714	0.707	0.829	0.837	0.829	0.970
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	Age 29 Rider	1.000	1.010	1.000	1.000	1.010	1.000	1.000
42	Non-Standard Plan Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**0.738**	**0.745**	**0.738**	**0.865**	**0.873**	**0.865**	**1.012**

Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**328.08**	**331.36**	**328.08**	**384.55**	**388.40**	**384.55**	**450.12**

Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
Gold	Gold	Platinum	Platinum	Platinum	Catastrophic	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
0.980	0.970	1.149	1.161	1.149	0.438	0.730	0.738	0.856	0.865	1.002	1.012	1.188	1.188
HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Gold with Dependent Age 29 & Dental, On-Exchange	Child-Only Gold with Dental, On-Exchange	Platinum with Dependent Age 26 & Dental, On-Exchange	Platinum with Dependent Age 29 & Dental, On-Exchange	Child-Only Platinum with Dental, On-Exchange	Catastrophic with Dependent Age 26 & Dental, On-Exchange	Bronze with Dependent Age 26 & Dental, On-Exchange, Non-standard	Bronze with Dependent Age 29 & Dental, On-Exchange, Non-standard	Silver with Dependent Age 26 & Dental, On-Exchange, Non-standard	Silver with Dependent Age 29 & Dental, On-Exchange, Non-standard	Gold with Dependent Age 26 & Dental, On-Exchange, Non-standard	Gold with Dependent Age 29 & Dental, On-Exchange, Non-standard	Platinum with Dependent Age 26 & Dental, On-Exchange, Non-standard	Platinum with Dependent Age 26 & Dental, On-Exchange, Non-standard
91237NY0020010	91237NY0020023	91237NY0020013	91237NY0020014	91237NY0020025	91237NY0020017	91237NY0020052	91237NY0020053	91237NY0020054	91237NY0020055	91237NY0020056	91237NY0020057	91237NY0020058	91237NY0020058
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

231.16	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**

Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
Gold	Gold	Platinum	Platinum	Platinum	Catastrophic	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
0.980	0.970	1.149	1.161	1.149	0.438	0.730	0.738	0.856	0.865	1.002	1.012	1.188	1.188

1.924	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**

0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
1.080	1.080	1.150	1.150	1.150	1.000	1.000	1.000	1.030	1.030	1.080	1.080	1.150	1.150
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.162	1.162	1.160	1.160	1.160	1.167	1.166	1.166	1.164	1.164	1.162	1.162	1.160	1.160
1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020
1.000	1.000	1.000	1.000	1.000	0.646	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
Gold	Gold	Platinum	Platinum	Platinum	Catastrophic	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
0.980	0.970	1.149	1.161	1.149	0.438	0.730	0.738	0.856	0.865	1.002	1.012	1.188	1.188
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.010	1.000	1.000	1.010	1.000	1.000	1.000	1.010	1.000	1.010	1.000	1.010	1.000	1.010
1.000	1.000	1.000	1.000	1.000	1.000	1.033	1.033	1.033	1.033	1.033	1.033	1.033	1.033
1.022	**1.012**	**1.200**	**1.212**	**1.200**	**0.457**	**0.762**	**0.770**	**0.894**	**0.903**	**1.046**	**1.056**	**1.240**	**1.252**

454.62	**450.12**	**533.44**	**538.77**	**533.44**	**203.20**	**339.01**	**342.40**	**397.37**	**401.34**	**465.12**	**469.77**	**551.22**	**556.73**

EXHIBIT 19 - SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Number: HLFT-129571607
Market Segment: Individuals On Exchange

1) Complete a separate ROW for Metal Level/Product
- Information should be for all the benefits included in that plan design including any riders (medical, drugs, etc).
- Enter in column 1 the Metal Tier level. Use the drop down menu.
- Enter in column 2 the plan designation as to On/Off Plan and Std/Non Standard Plan. Use the drop down menu.
- Enter in column 3 the Estimated Membership as of a recent date mm/dd/yyy; enter the date in column heading.
- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

2) The average claim trend is the average annualized claim trend that is used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

3) Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the requested rates and the average annual claim trend assumed.

4) Enter the corresponding information requested for the immediately prior rate and form filing. This refers to the various expense components in the requested rates submitted for the immediately prior rate and form filing and the average claim trend assumed. If there is no immediately prior rate and form filing, enter the data from the initial rate and form filing.

5) **ACA Fees** are to be entered in columns 6.5 and 16.5.

6) This exhibit must be submitted as an Excel file and as a PDF file.

				For the rate period included in this rate adjustment filing											For the rate period included in this rate adjustment filing							
1. Metal Level [drop down menu]	2. On/Off Exchange Designation **and** Standard/Non Std [drop down menu]	3. Estimated Membership as of mm/dd/yyyy		4.1 Period assumed beginning date (mm/dd/yy)	4.2 Period assumed ending date (mm/dd/yy)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	
Platinum	On Std	434	XX	01/01/15	12/31/15	7.56%	0.78%	0.62%	0.00%	0.00%	0.73%	11.38%	13.51%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.51%	XX
Gold	On Std	313	XX	01/01/15	12/31/15	7.56%	0.78%	0.62%	0.00%	0.00%	0.87%	11.38%	13.65%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.65%	XX
Silver	On Std	5,781	XX	01/01/15	12/31/15	7.56%	0.78%	0.62%	0.00%	0.00%	1.02%	11.38%	13.80%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.80%	XX
Bronze	On Std	878	XX	01/01/15	12/31/15	7.56%	0.78%	0.62%	0.00%	0.00%	1.19%	11.38%	13.97%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.97%	XX
Catastrophic	On Std	6	XX	01/01/15	12/31/15	7.56%	0.78%	0.62%	0.00%	0.00%	1.93%	11.38%	14.71%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.71%	XX
Platinum	On Non Std	NA	XX	01/01/15	12/31/15	7.56%	0.78%	0.62%	0.00%	0.00%	0.71%	11.38%	13.49%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.49%	XX
Gold	On Non Std	NA	XX	01/01/15	12/31/15	7.56%	0.78%	0.62%	0.00%	0.00%	0.84%	11.38%	13.62%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.62%	XX
Silver	On Non Std	NA	XX	01/01/15	12/31/15	7.56%	0.78%	0.62%	0.00%	0.00%	0.99%	11.38%	13.77%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.77%	XX
Bronze	On Non Std	NA	XX	01/01/15	12/31/15	7.56%	0.78%	0.62%	0.00%	0.00%	1.15%	11.38%	13.93%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.93%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX

EXHIBIT 19: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES

				For the rate period included in the prior rate and form filing										For the rate period included in the prior rate and form filing							
1. Metal Level [drop down menu]	2. On/Off Exchange Designation **and** Standard/Non Std [drop down menu]	3. Estimated Membership as of mm/dd/yyyy		14.1 Period assumed - beginning date (mm/dd/yy)	14.2 Period assumed - ending date (mm/dd/yy)	15. Average annual claim trend assumed	16.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	16.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	16.3 Commissions and broker fees - as a % of gross premium	16.4 Premium Taxes - as a % of gross premium	16.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	16.6 Other administrative expenses - as a % of gross premium	16.7 Subtotal columns 20.1 through 20.6	17 After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	18 State income tax component - as a % of gross premium	18.1 State income tax rate assumed (eg 3%)	19 Federal income tax component - as a % of gross premium	19.1 Federal income tax rate assumed (eg 30%)	20 Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	21 Subtotal columns 16.7 + 17 + 18 + 19 +20
Platinum	On Std	434	XX	01/01/14	12/31/14	8.00%	0.86%	0.76%	0.00%	0.00%	0.97%	11.24%	13.83%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.83%
Gold	On Std	313	XX	01/01/14	12/31/14	8.00%	0.86%	0.76%	0.00%	0.00%	1.15%	11.24%	14.01%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.01%
Silver	On Std	5,781	XX	01/01/14	12/31/14	8.00%	0.86%	0.76%	0.00%	0.00%	1.34%	11.24%	14.20%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.20%
Bronze	On Std	878	XX	01/01/14	12/31/14	8.00%	0.86%	0.76%	0.00%	0.00%	1.57%	11.24%	14.43%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.43%
Catastrophic	On Std	6	XX	01/01/14	12/31/14	8.00%	0.86%	0.76%	0.00%	0.00%	1.86%	11.24%	14.72%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.72%
Platinum	On Non Std	NA	XX	NA	NA	NA	NA	NA	NA	NA	NA	NA	#VALUE!	NA	NA	NA	NA	NA	NA	#VALUE!
Gold	On Non Std	NA	XX	NA	NA	NA	NA	NA	NA	NA	NA	NA	#VALUE!	NA	NA	NA	NA	NA	NA	#VALUE!
Silver	On Non Std	NA	XX	NA	NA	NA	NA	NA	NA	NA	NA	NA	#VALUE!	NA	NA	NA	NA	NA	NA	#VALUE!
Bronze	On Non Std	NA	XX	NA	NA	NA	NA	NA	NA	NA	NA	NA	#VALUE!	NA	NA	NA	NA	NA	NA	#VALUE!
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%
			XX										0.00%							0.00%

EXHIBIT 20: HIOS ID MAPPING TO PRODUCT NAMES

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Number: HLFT-129571607
Market Segment: Individuals On Exchange

1) This exhibit is to help DFS reconcile the 14 digit HIOS IDs used to the different plan designs and to reconcile the rate manual to the binder rate template.
2) The HIOS IDs should be without the variants after the hyphen.
3) Column 3: Enter Metal Level. Use drop down menu.
4) Column 4: Enter On/Off Plan Designation. Use drop down menu.
5) Column 5: Enter Standard/Non Standard Plan Designation. Use drop down menu.
6) Column 6: Enter coverage of children to 26th birthday (26) or to 30th birthday. Use drop down menu.
7) Column 7: Enter Yes/No for coverage of Domestic Partner. Use drop down menu.
8) Column 8: Enter Yes/No for coverage of Family Planning. Use drop down menu.
9) Column 9: Enter Yes/No for coverage of Embedded Pediatric Dental. Use drop down menu.
10) Column 10: Enter Yes/No for coverage of Out of Network Benefits [PPO or POS]. Use drop down menu.
11) Column 11: Indicate if the plan design includes benefits in addition to the EHB benefits (yes) or (no). Use drop down menu.
12) This exhibit must be submitted as an Excel and as PDF file.

1 HIOS ID	2 Rate Manual Plan Name	3 Metal Level	4 Exchange Plan? (on, off, both)	5 Standard Plan Design? (yes, no)	6 Limiting Child Age? (26 or 30)	7 Domestic Partner Coverage Included? (yes, no)	8 Family Planning Coverage? (included, excluded)	9 Pediatric Dental Coverage Included? (yes, no)	10. Out of Network Benefits? (yes, no)	11 Include Benefits in Addition to EHB? (yes, no)
91237NY0020001	Healthfirst Bronze Leaf	Bronze	ON	YES	26	YES	INCLUDED	YES	NO	NO
91237NY0020002	Healthfirst Bronze Leaf	Bronze	ON	YES	29	YES	INCLUDED	YES	NO	NO
91237NY0020019	Healthfirst Bronze Leaf Child-Only	Bronze	ON	YES	26	YES	INCLUDED	YES	NO	NO
91237NY0020005	Healthfirst Silver Leaf	Silver	ON	YES	26	YES	INCLUDED	YES	NO	NO
91237NY0020006	Healthfirst Silver Leaf	Silver	ON	YES	29	YES	INCLUDED	YES	NO	NO
91237NY0020021	Healthfirst Silver Leaf Child-Only	Silver	ON	YES	26	YES	INCLUDED	YES	NO	NO
91237NY0020009	Healthfirst Gold Leaf	Gold	ON	YES	26	YES	INCLUDED	YES	NO	NO
91237NY0020010	Healthfirst Gold Leaf	Gold	ON	YES	29	YES	INCLUDED	YES	NO	NO
91237NY0020023	Healthfirst Gold Leaf Child-Only	Gold	ON	YES	26	YES	INCLUDED	YES	NO	NO
91237NY0020013	Healthfirst Platinum Leaf	Platinum	ON	YES	26	YES	INCLUDED	YES	NO	NO
91237NY0020014	Healthfirst Platinum Leaf	Platinum	ON	YES	29	YES	INCLUDED	YES	NO	NO
91237NY0020025	Healthfirst Platinum Leaf Child-Only	Platinum	ON	YES	26	YES	INCLUDED	YES	NO	NO
91237NY0020017	Healthfirst Green Leaf	Catastrophic	ON	YES	26	YES	INCLUDED	YES	NO	NO
91237NY0020052	Healthfirst Bronze Leaf Premier	Bronze	ON	NO	26	YES	INCLUDED	YES	NO	YES
91237NY0020053	Healthfirst Bronze Leaf Premier	Bronze	ON	NO	29	YES	INCLUDED	YES	NO	YES
91237NY0020054	Healthfirst Silver Leaf Premier	Silver	ON	NO	26	YES	INCLUDED	YES	NO	YES
91237NY0020055	Healthfirst Silver Leaf Premier	Silver	ON	NO	29	YES	INCLUDED	YES	NO	YES
91237NY0020056	Healthfirst Gold Leaf Premier	Gold	ON	NO	26	YES	INCLUDED	YES	NO	YES
91237NY0020057	Healthfirst Gold Leaf Premier	Gold	ON	NO	29	YES	INCLUDED	YES	NO	YES
91237NY0020058	Healthfirst Platinum Leaf Premier	Platinum	ON	NO	26	YES	INCLUDED	YES	NO	YES
91237NY0020059	Healthfirst Platinum Leaf Premier	Platinum	ON	NO	29	YES	INCLUDED	YES	NO	YES

EXHIBIT 23: SUMMARY OF REQUESTED 2015 PREMIUM RATES

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Number: HLFT-129571607
Market Segment: iduals On Exchange

1) Purpose of this Exhibit is to summarize all Premium Rates for all Metal Levels and for all Regions.
2) Premium rates are Calendar Year 2015 premium rates for Individual Only on Individual Plans and First Quarter 2015 premium rates for Employee Only on Small Group Plans.
3) Premium rates are only for plans with the following benefit provisions:
   (a) Through Age 29; **and**
   (b) With Domestic Partner; **and**
   (c) With Family Planning.
4) This exhibit must be submitted as an Excel and as a PDF file.

SUMMARY OF REQUESTED 2015 PREMIUM RATES

1. HIOS ID PLAN (14 Digits)	2. Metal Level or Catastrophic	3. Exchange [Ind/Sml Grp]	4. On/Off Exchange	5. Plan Type [Std or Non Std]	6. Pediatric Dental [Yes/No]	Region 1 Albany	Region 2 Buffalo	Region 3 Mid-Hudson	Region 4 New York	Region 5 Rochester	Region 6 Syracuse	Region 7 Utica	Region 8 Long Island
91237NY0020	Bronze	IND	On	Standard	Yes	$0.00	$0.00	$0.00	$342.50	$0.00	$0.00	$0.00	$342.50
91237NY0020	Silver	IND	On	Standard	Yes	$0.00	$0.00	$0.00	$401.45	$0.00	$0.00	$0.00	$401.45
91237NY0020	Gold	IND	On	Standard	Yes	$0.00	$0.00	$0.00	$469.90	$0.00	$0.00	$0.00	$469.90
91237NY0020	Platinum	IND	On	Standard	Yes	$0.00	$0.00	$0.00	$556.88	$0.00	$0.00	$0.00	$556.88
91237NY0020	Bronze	IND	On	Non-Standard	Yes	$0.00	$0.00	$0.00	$353.91	$0.00	$0.00	$0.00	$353.91
91237NY0020	Silver	IND	On	Non-Standard	Yes	$0.00	$0.00	$0.00	$414.83	$0.00	$0.00	$0.00	$414.83
91237NY0020	Gold	IND	On	Non-Standard	Yes	$0.00	$0.00	$0.00	$485.56	$0.00	$0.00	$0.00	$485.56
91237NY0020	Platinum	IND	On	Non-Standard	Yes	$0.00	$0.00	$0.00	$575.44	$0.00	$0.00	$0.00	$575.44
91237NY0020	Catastrophic	IND	On	Standard	Yes	$0.00	$0.00	$0.00	$210.03	$0.00	$0.00	$0.00	$210.03

healthfirst

6/5/2014

«SubscirberFirstName» «SubscriberLastName»
«AddressLine1» «AddressLine2»
«CITY», «STATE» «ZipCode»

Re: Notice of Proposed Premium Rate Reduction
Healthfirst [Plan Name] - HIOS ID 91237NY002[XXXX]

Dear Healthfirst Member:

Healthfirst PHSP, Inc. (Healthfirst) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Reduction
If approved, the percentage reduction to your premium will be 9.8%. This means that your monthly premium may be lower starting January 1, 2015.

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features you select on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

Why We Are Requesting a Rate Reduction
While several market forces continue to drive health care costs higher, Healthfirst is requesting a lower rate in 2015. We continue to improve our care management and quality improvement programs. We also continue to strengthen our robust network. In addition, the demographic make-up of our current membership is different than was expected.

Based on these factors, as well as our projections, the membership's average demand for medical services may go down in 2015. This is why we are applying for a rate reduction to account for marketplace trends and to reflect these changing factors.

30-day Comment Period
You can contact us or DFS to ask for more information or submit comments to DFS about the proposed rate changes. The comments must be made within 30 days from the date of this notice.

healthfirst

You can contact Healthfirst for additional information at:

Healthfirst PHSP, Inc.
100 Church Street
New York, NY
1-888-250-2220
www.healthfirst.org

Comments or requests for more information on the proposed rate change may be submitted to:

NYS Department of Financial Services
Health Bureau – Premium Rate Adjustments
1 State Street
New York, NY, 10004
Email: premiumrateincrease@dfs.ny.gov
DFS Website: www.dfs.ny.gov/healthinsurancepremiums

If you choose to submit comments to DFS, please include the following information:

1. The name of your insurer, which is Healthfirst PHSP, Inc.
2. The name of your plan, which is Healthfirst [Plan Name]
3. Indicate you have individual coverage
4. Your HIOS identification number, which is 91237NY002[XXXX]

Written comments submitted to DFS will be posted on the DFS website with all your personal information removed.

Plain English Summary of Rate Reduction
We have prepared a plain-English summary that provides a more detailed explanation of the reasons why a premium rate change is being requested. You can find this information at the following websites:

Healthfirst website: www.healthfirst.org/priorapproval
DFS website: http://www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate
After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,

Nemesio Ortiz
Vice President, Sales
Healthfirst

June 13, 2014

RE: Healthfirst PHSP, Inc. – Individual On-Exchange Plans

We have prepared the enclosed submission, pursuant to section 4308(c) of the New York Insurance Law, for Individual On-Exchange rates to be effective on January 1, 2015. The rates are for the New York City region which includes Bronx, Kings, New York, Queens, and Richmond Counties; and the Long Island region which includes Nassau and Suffolk Counties.

If you have any questions concerning this submission, please feel free to contact me at . We look forward to continue working with the Department and New York State of Health.

Sincerely,

Confidential and Proprietary

Healthfirst PHSP, Inc.

Part III Actuarial Memorandum

Individual Rate Filing

On-Exchange

Effective January 1, 2015

TABLE OF CONTENTS

1. GENERAL INFORMATION 1
2. PROPOSED RATE INCREASE(S) 2
3. EXPERIENCE PERIOD PREMIUM AND CLAIMS 2
4. BENEFIT CATEGORIES 3
5. PROJECTION FACTORS 3
6. CREDIBILITY MANUAL RATE DEVELOPMENT 3
7. CREDIBILITY OF EXPERIENCE 5
8. PAID TO ALLOWED RATIO 6
9. RISK ADJUSTMENT AND REINSURANCE 6
10. NON-BENEFIT EXPENSES AND PROFIT & RISK 7
11. PROJECTED LOSS RATIO 9
12. SINGLE RISK POOL 9
13. INDEX RATE 9
14. MARKET ADJUSTED INDEX RATES 9
15. PLAN ADJUSTED INDEX RATES 10
16. CALIBRATION 11
17. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT 11
18. AV METAL VALUES 12
19. AV PRICING VALUES 12
20. MEMBERSHIP PROJECTIONS 12
21. TERMINATED PRODUCTS 13
22. PLAN TYPE 13
23. WARNING ALERTS 13
24. RELIANCE 14
25. ACTUARIAL CERTIFICATION 14

1. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Healthfirst PHSP, Inc. (Healthfirst) rate filing, for the Individual block of business with an effective date of January 1, 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This memorandum is intended for use by the New York Department of Financial Services (DFS), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Healthfirst's Individual rate filing. The memorandum contains information that is confidential and proprietary to Healthfirst; therefore, the memorandum should not be distributed to any other parties unless required by law.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons including population changes, claims experience, and other deviations from assumptions.

Company Identifying Information

- Company Legal Name: Healthfirst PHSP, Inc.
- State: New York
- HIOS Issuer ID: [redacted]
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

2. Proposed Rate Increase(s)

Healthfirst is proposing an overall 9.8% rate decrease for their existing plans. The rate decrease varies by plan as shown in Worksheet 2 of the URRT. The proposed rates are effective January 1, 2015.

Note the following plan changes in 2015:

- Healthfirst is adding the following plans that offer non-standard Adult Dental and Vision benefits.

Benefit Design	HIOS Plan ID	On/Off Exchange	Metal Tier Level
Bronze with Dependent Age 26 & Dental, On-Exchange, Non-standard	91237NY0020052	On Exchange	Bronze
Bronze with Dependent Age 29 & Dental, On-Exchange, Non-standard	91237NY0020053	On Exchange	Bronze
Silver with Dependent Age 26 & Dental, On-Exchange, Non-standard	91237NY0020054	On Exchange	Silver
Silver with Dependent Age 29 & Dental, On-Exchange, Non-standard	91237NY0020055	On Exchange	Silver
Gold with Dependent Age 26 & Dental, On-Exchange, Non-standard	91237NY0020056	On Exchange	Gold
Gold with Dependent Age 29 & Dental, On-Exchange, Non-standard	91237NY0020057	On Exchange	Gold
Platinum with Dependent Age 26 & Dental, On-Exchange, Non-standard	91237NY0020058	On Exchange	Platinum
Platinum with Dependent Age 29 & Dental, On-Exchange, Non-standard	91237NY0020059	On Exchange	Platinum

Reason for Rate Changes

The major contributors to the rate changes include lower than expected claim trend, changes in network utilization, changes in benefits, changes in expected enrollment demographics, and changes in the reinsurance fees and parameters, all of which are discussed in more detail throughout this filing.

3. Experience Period Premium and Claims

Paid through Date

Healthfirst did not offer Individual insurance in 2013; therefore, no experience is populated in Worksheet 1. The rates were developed based upon 100% manual rates, as described below in the Credibility Manual Rate Development section.

Premiums (net of MLR Rebate) in Experience Period

Not applicable. No experience to report.

Allowed and Paid Claims Incurred During the Experience Period

Not applicable. No experience to report.

4. Benefit Categories

The services included in each benefit category of the URRT are consistent with the definitions of the benefit categories included in the URRT instructions. The "Other Medical" category includes home health care, ambulance, DME/ prosthetics, glasses/contacts, and pediatric dental services.

5. Projection Factors

Not applicable. Healthfirst did not have experience during the base period. See the Credibility Manual Rate Development section, just below, for a discussion of the projection factors.

6. Credibility Manual Rate Development -

Source and Appropriateness of Data Used

The manual rate was developed based on Healthfirst's Family Health Plus (FHP) experience for claims incurred in CY 2013 and paid through February 28, 2014. The FHP experience represents 72,000 members which is made up of 55,000 Healthfirst FHP members and 17,000 Neighborhood Health Plan (NHP) FHP members. Healthfirst acquired NHP in 2013 and only seven months of incurred data from June 1, 2013 to December 31, 2013 was available for NHP under Healthfirst contracts. CY 2013 was estimated based on extrapolating the seven months of available data.

The FHP experience was projected to 2015, and adjusted to reflect the changes from the FHP experience to that with which is expected under the Individual product. The factors include changes in provider reimbursement, in and out-of-network utilization, benefits, benefit richness, an adjustment for the Cost Sharing Reduction (CSR) plans, a population change factor and pent-up demand. The adjustments are discussed in detail below.

A corresponding HHS risk score was calculated using this same data in order to have consistency between the claims and the risk score used in the rate development. For NHP, 12 months of diagnoses data was available to calculate a risk score.

Adjustments Made to the Data

The following adjustments were made to the starting FHP data discussed above. Each one of these factors is included in Exhibit 18 required by New York State. For your review, we have included the market-wide adjustments from Exhibit 18 in **Appendix A** and have identified the line numbers from Exhibit 18 that reference the adjustments discussed below.

- Paid-to-Allowed and Induced Utilization (*Line 11*) – The starting FHP data is on a paid basis, and was adjusted to an allowed PMPM using a paid-to-allowed ratio of 0.979, based on the FHP experience. The starting data was also adjusted to remove the induced utilization that corresponds to experience with a paid-to-allowed ratio of 0.979. The induced utilization factor is 1.15, and was based on the HHS induced utilization factors. The combination of these factors produces the AV Pricing Value of 1.126 on Line 11.

- Benefits (*Line 13*) – It was assumed that the additional Essential Health Benefits (EHBs) covered under ACA would represent a cost increase of approximately 6.4% over current FHP benefits.

- Provider Network (*Line 14*) – Healthfirst's QHP network represents more than 90% of our current FHP network. The 'Market wide adjustment for changes in provider network' of 0.991 represents the impact of this slightly narrower network.

- Provider Reimbursement and Out-of-Network (OON) Utilization (*Line 15*) – Please note that the Provider Reimbursement adjustment and Out-of-Network Utilization adjustment were combined as "Market wide adjustment for fee schedule changes" in Exhibit 18. The adjustment factor is calculated as (1.197 x 1.156 = 1.384). Each component is discussed below:

  - Provider Reimbursement – The FHP reimbursement levels were increased by [redacted] to adjust the base period experience to reflect Healthfirst's expected reimbursement levels in 2015 for the individual product.

  - Out-of-Network (OON) Utilization – FHP experience reflects minimal OON utilization. Based on Healthfirst's emerging 2014 individual experience, we are expecting significantly more OON utilization, as well as higher OON reimbursement rates, compared to our base FHP experience. To reflect these changes, the experience was increased by 15.6%.

- Utilization Management; Quality Improvement and Cost Containment Adjustment (*Lines 16 and 17*) – There are no specific changes to our utilization management, quality improvement, and cost containment initiatives for our QHP programs compared to FHP PHSP. Hence, no adjustment was made to our base experience.

- Impact on Risk Pool of Changes in Expected Covered Membership Risk Characteristics (Line 18). Please note that the Population Change, CSR adjustment, and Pent-up Demand were combined in Line 18 of Exhibit 18, and are discussed below. The adjustment factor is calculated as (1.046 x 1.076 x 1.022 = 1.150)

  - Population Change – A population adjustment was made to the manual rate to reflect differences in the enrollment mix by age and gender between the FHP population and the individual population expected to enroll with Healthfirst in 2015. The adjustment was based on age/gender factors from the Milliman Health Cost Guidelines, and reflects expected differences between the average age/gender of the FHP population used for our base experience and the population expected to enroll in the individual product. The population change adjustment factor is 1.046.

- CSR Adjustment – The 7.6% adjustment reflects the additional utilization expected for the members enrolled in the CSR plans, due to their lower cost sharing. The HHS CSR factors were used to calculate an average CSR load which was then applied to all plans.

- Pent-up Demand – A 2.2% factor was applied to the base experience to reflect the expected first year additional cost due to pent-up demand from members enrolling in the individual product who were previously uninsured. We assumed that the previously uninsured new enrollment, roughly 22% of the total enrollment, will use 10% more services.

- Federal Risk Adjustment (Line 21) – Healthfirst is expecting a minimal risk transfer payment, which is discussed in more detail in Section 9 below. This equates to reducing the experience slightly by 0.5% (applying a factor of 0.995).

- Federal Transitional Reinsurance Program Recovery (Line 22) – The impact of the reinsurance program was estimated to be a 6% reduction to net claims prior to the covered lives assessment, or 5.7% after the covered lives assessment.

- Trend (Line 24) – An annual trend of 7.6% was assumed. The trend was based on our review of our historical FHP trends as well as projected industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state. The factor of 1.157 represents trends for a 24-month period.

- Covered Lives Assessment (Line 25) – Covered Lives Assessment is added to the base FHP medical expenses. Our estimates were based on the following:

  - 2014 Covered Lives Assessments were used since they are the latest published assessments. New York City assessments of $197.69 per Individual contract per year and $652.39 per Family contract were used; Long island assessments of $61.96 per Individual contract and $204.48 per Family contract were used.
  - An estimated 90% of our contracts would be in New York City based on our current membership distribution.
  - Using a tier distribution (that will be described in Section 17.B. “Conversion Factor”), the per-contract per year assessment was determined to be $376.91, or $18.72 PMPM. This equates to an adjustment factor of 1.056.

Inclusion of Capitation Payments

No capitated arrangements were included in the manual rate development.

7. Credibility of Experience

Since Healthfirst did not start offering Individual policies until 2014, we did not include any experience in the experience section of the URRT. Our results are based entirely on the manual rate. The experience section of the URRT was populated with 1's and 0's to allow for finalization.

8. Paid to Allowed Ratio

Average paid-to-allowed ratios by plan were developed using the HHS Actuarial Value Calculator. The ratios by metallic level are as follows:

Metallic Level	Paid to Allowed Ratio
Platinum	0.881
Gold	0.791
Silver	0.707
Bronze	0.620
Catastrophic	0.594

9. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

- An average HHS risk score was developed for the individual population using diagnoses and enrollment data consistent with the FHP data that was described in the development of the manual rate. To reflect Healthfirst's expected 2015 individual membership, the HHS risk score was adjusted to reflect projected 2015 AVs by metal level and CSR variation as well as the population factor discussed in Section 6 above.

- The statewide HHS risk score was developed using a blend of data published by DFS for the 2013 individual market (67%) and 2013 MarketScan© commercial data for New York (33%), adjusted to reflect the anticipated 2015 mix of plans by metal level and CSR variation.

- The statewide premium reflects a blend of the same populations used to develop the statewide risk score.

- The calculation of the risk transfer amount was based on the prescribed methodology, and is summarized below.

Risk Transfer Calculation	
Risk Factors less Rating Factors	0.004
Projected Statewide Premium	$468.99
Risk Transfer Received / (Paid)	$1.74
Administrative Expense	$0.08
Net Risk Transfer Received / (Paid)	$1.66

The Healthfirst average risk level is projected to be slightly above the statewide average risk level for the metallic plans, leading to the receipt of a risk transfer amount by Healthfirst. The Healthfirst average risk level is projected to be comparable to the statewide average risk level for the catastrophic plans, leading to no risk transfer payment by Healthfirst.

The risk transfer amounts were allocated proportionally to all plans based on plan premium. The administrative expense PMPM of $0.08 was applied on a PMPM basis for all plans.

Projected ACA Reinsurance Recoveries Net of Reinsurance

Reinsurance recoveries were estimated to be 6.0% of net claims cost, or $20.12 PMPM, based on DFS's estimate.

Anticipated reinsurance revenue is allocated proportionally based on plan premiums for all plans within a risk pool by applying the reinsurance adjustment factor as a constant multiplicative factor across all plans. The Transitional Reinsurance Program Fee of $3.67 PMPM was used for all plans, and was included in our administrative expenses.

10. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

Healthfirst's utilized an allocation methodology that distributes departmental costs using driver-based allocation, for example, membership, number of claims, number of calls, premium revenue, etc. We also distinguish departments between "fixed and variable" depending on the impact of membership growth on staffing levels. For example, Claims is considered a variable department since claims volume varies proportionately by membership. On the other hand, Finance Corporate, for example, is a department unaffected by membership growth for the most part.

Exchange administrative projections were driven by two main components – Projected 2015 membership, premium revenue and medical costs under our On-Exchange products were used to drive cost allocations for "variable" departments while a "current run-rate" PMPM was used to drive "fixed" departments, with nominal inflation.

Our administrative costs for all our On-Exchange QHP line of business include the following:

- Healthfirst Management Services, LLC (HFMS) will be contracted at twelve percent of premium for all the administrative activities of the PHSP QHP products. This will include, but not limited to, marketing and sales, enrollment, claims administration, medical management, member services, network management, product management, clinical and quality performance management, compliance, legal, regulatory, finance and actuarial. This fee will not include the taxes and fees described below.

- This includes the quality improvement/cost containment programs that impact the health plans, estimated at 0.62% of premium. Please refer to **Appendix B** for a description of all quality improvement/cost containment programs that impact the health plans included in the risk pool. This should tie in with the activities that improve health care quality, as specified in Exhibit 19 (DFS), the HHS MLR report and the Supplemental Health Care Exhibit.

The percentage load was applied to all plans.

Profit (or Contribution to Surplus) & Risk Margin

Profit or Contribution to Surplus margin of 2% was included in all plans. This is consistent with our current ROI for other products. Healthfirst recognizes the need to have positive margins on our programs. We believe that our 2.0% operating margin would provide necessary capital to invest in the company's infrastructure, provide adequate capital to meet reserve requirements for Healthfirst, and provide high quality care to our members.

The ROI for Healthfirst's investment portfolio in calendar years 2009 through 2013 are as follows:

Year	Total Rate of Return
2013	0.01%
2012	1.76%
2011	0.68%
2010	2.98%
2009	5.10%

The average ROI for the last five years was 2.11% for Healthfirst PHSP.

Taxes and Fees

The following taxes and fees are included in the premium rates:

- Patient-Centered Outcomes Research (PCORI) Tax of $2.00 per member per year;
- Transitional Reinsurance Program Fee of $3.67 PMPM;
- Risk Adjustment User Fee of $0.08 PMPM;
- New York State 332 Assessment estimated to be approximately 0.78% of premium;
- Health Insurance Excise Tax (ACA Premium Tax) is not included. Healthfirst is exempt in 2015 since
    i. It is incorporated as a nonprofit corporation under state law;
    ii. No part of the entity's profits inure to any private shareholder or individual, no substantial part of its activities include carrying on propaganda or otherwise attempting to influence legislation, and does not participate in or intervene in any

political campaign on behalf of or in opposition to any candidate for public office, and

iii. More than 80% of the entity's gross revenues are received from government programs that target low income, disabled or elderly populations.

- As a non-profit organization, Healthfirst does not pay any other State or Federal taxes or assessments.
- Since New York has determined that there will be no Exchange user fee for 2015, no adjustment was incorporated in our 2015 rates.

11. Projected Loss Ratio

Two loss ratios are calculated, one consistent with the New York State prescribed Medical Loss Ratio (MLR) methodology and one based on the Federal definition. The anticipated New York MLR is 84.2% relative to total premium, which exceeds the minimum allowable MLR of 82%. The anticipated Federal MLR is 86.4%, prior to credibility, which exceeds the Federal minimum MLR of 80%.

12. Single Risk Pool

Premium rates were not developed from historical experience as Healthfirst did not sell individual policies until January 2014.

13. Index Rate

The index rate was developed using the manual rate projection that was described in Section 6. The index rate is shown in Worksheet 1 of the URRT. The index rate reflects the estimated allowed claims cost PMPM for EHBs, prior to any adjustments for risk transfer or reinsurance.

14. Market Adjusted Index Rates

The Market Adjusted Index rate is calculated as the Index Rate adjusted for allowable market-wide adjustments. The market-wide adjustments are the net risk adjustment, the net federal reinsurance program costs, and the Exchange user fee, which are discussed in Sections 9 and 10 above. The Exchange user fee is $0.00 in New York State. The following table shows the calculation of Healthfirst's Market Adjusted Index Rate:

Market Adjusted Index Rate	
Index Rate	$482.23
Net Risk Adjustment	($1.66)
Net Transitional Reinsurance	($16.45)
Exchange Fee	0.00
Market Adjusted Index Rate	$464.12

15. Plan Adjusted Index Rates

The Plan Adjusted Index Rates are calculated in Exhibit 18 (**Appendix C**). Below is a description of the development. Although Healthfirst did not enter the individual market until 2014, New York State requires that the starting experience in the development of the individual rates be included in Exhibit 18. As discussed in Section 6 above, the starting experience is Healthfirst's CY 2013 FHP experience.

- Lines 10A – 12: Experience Period
  - Lines 10A – 10C: Shows the starting FHP net paid PMPM.
  - Lines 11 – 12: The FHP net paid PMPM is adjusted to an allowed PMPM level and adjusted to remove the induced utilization that is included in the starting experience, as discussed in Section 6 above.
- Lines 13 - 28: Market Wide Adjustments as discussed in detail in Section 6 above.
- Lines 29 – 43: Plan Level Adjustments.
  - The rate is adjusted for plan specific adjustments, as listed below and described earlier:
    - Pricing actuarial value
    - Induced Demand
    - Administrative expenses
    - Profit
    - Catastrophic plans eligibility adjustment – The average age for members enrolled in the metal plans is expected to be much higher than the average age for members enrolled in the catastrophic plan due to the eligibility limits for the catastrophic plan. Therefore, the cost for the metal plans was increased slightly while the cost for the catastrophic plans was decreased to reflect the differences in the average age for each pool relative to the combined pool. The adjustments were developed using age/gender factors from the Milliman Health Cost Guidelines.
    - Age 29 Rider Adjustment: For applicable plans.
    - Non- Standard Plan Adjustments: Adult Dental and Adult Vision benefits were added for applicable plans.
- Line 44: Plan adjusted index rate.

16. Calibration

No rate calibration was needed.

17. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed based on the plan adjusted index rate, which is on a PMPM basis, adjusted to reflect the required rate for each contract type. It is the final premium rate per contract, and the same rates are used for both the New York City and Long Island rating areas.

A. Standard Rating Regions

Healthfirst participates in two of the eight standardized rating regions in New York State:

- New York – Our service area includes Bronx, Kings, New York, Queens and Richmond.
- Long Island – Our service area includes Nassau and Suffolk.

The area factors to be used for 2015 are as follows:

Region	Counties included	Area factor
New York City	Bronx, Kings, New York, Queens, Richmond	1.000
Long Island	Nassau, Suffolk	1.000

Please note that these area factors are to be applied to the Index Rates shown for each QHP plan.

We determined that the area factors for these two regions are the same, which is consistent with our rating approach for our other products including Individual HMO, Healthy New York products, as well as Child Health Plus products.

B. Conversion Factor

The final premium rates for Employee Only, Employee and Spouse, Employee and Child(ren) and Employee/Spouse/Child(ren) are based on census factors prescribed by DFS:

Census Tiers	Relativity
Single	1.000
Single + Spouse	2.000
Single + Child(ren)	1.700
Single + Spouse + Child(ren)	2.850
Child Only	0.412

For a Child Only plan that covers two children in a family, the premium rate would be twice the one child premium rate. For a Child Only plan that covers three or more children in a family, the premium rate would be three times the one child premium rate, consistent with HHS Regulations.

We assumed a tier distribution that is similar to that of our year-to-date QHP experience. The development of the conversion factor is shown in the table below:

Census Tiers	Contract Distribution	Cost Per Contract	Number Of Members Per Contract	Loading Factor
Single	73.1%	1.000	1.000	1.034
Single + Spouse	22.4%	2.000	2.000	2.067
Single + Child(ren)	1.4%	1.700	2.629	1.757
Single + Spouse + Child(ren)	1.9%	2.850	4.019	2.946
Child Only	1.2%	0.412	1.000	0.426
Total	100.0%	1.261	1.303	1.303

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based entirely on the Federal AV Calculator. No adjustments were needed for any benefits from those values produced by the AV calculator.

19. AV Pricing Values

The AV Pricing Value includes the impact of cost sharing, the utilization impact of the cost sharing, and other allowable plan specific adjustments to the index rate. Each of the plan specific adjustments can be seen in Exhibit 18. The utilization adjustments due to cost sharing are based on the HHS induced utilization factors, and do not include health status adjustments.

20. Membership Projections

The membership projections are based on a blend of the current Healthfirst FHP members expected to transition to the individual market, current 2014 Healthfirst Individual enrollment, and new enrollment with demographics similar to the current individual market. Membership by plan is shown on Worksheet 2 of the URRT.

We also assume that the proportion of enrollment in CSR plans is similar to our current membership distribution, shown in chart below:

Plans	% Membership

Plans	% Membership
Platinum	6.0%
Gold	4.2%
Silver 94	30.8%
Silver 87	33.0%
Silver 73	7.9%
Silver	7.0%
Bronze	11.1%
Catastrophic	0.1%
	100.0%

21. Terminated Products

Healthfirst is terminating products in 2014 that do not offer pediatric dental.

Benefit Design	HIOS Plan ID	On/Off Exchange	Metal Tier Level
Bronze with Dependent Age 26 No Dental	91237NY0020003	On Exchange	Bronze
Bronze with Dependent Age 29 No Dental	91237NY0020004	On Exchange	Bronze
Silver with Dependent Age 26 No Dental	91237NY0020007	On Exchange	Silver
Silver with Dependent Age 29 No Dental	91237NY0020008	On Exchange	Silver
Gold with Dependent Age 26 No Dental	91237NY0020011	On Exchange	Gold
Gold with Dependent Age 29 No Dental	91237NY0020012	On Exchange	Gold
Platinum with Dependent Age 26 No Dental	91237NY0020015	On Exchange	Platinum
Platinum with Dependent Age 29 No Dental	91237NY0020016	On Exchange	Platinum
Catastrophic with Dependent Age 26 No Dental	91237NY0020018	On Exchange	Catastrophic
Child-Only Bronze No Dental	91237NY0020020	On Exchange	Bronze
Child-Only Silver No Dental	91237NY0020022	On Exchange	Silver
Child-Only Gold No Dental	91237NY0020024	On Exchange	Gold
Child-Only Platinum No Dental	91237NY0020026	On Exchange	Platinum

22. Plan Type

The Plan types listed in the URRT accurately describe Healthfirst's plans.

23. Warning Alerts

The following validation warnings occurred when finalizing the URRT workbook.

- WARNING - Wksh 1 - Market Experience - Cell F18 - Must be > 0 if Allowed Claims (Cell F16) is greater than 0.
  - Explanation – HF had no membership in 2013. Failing to enter non-zero Allowed Claims in Cell F16 would result in a validation error ("ERROR - Wksh 1 - Market Experience - Cell F16 - (Allowed Claims) is required.").

24. Reliance

In the preparation of this filing, I relied upon data provided by Milliman including the following items:

- Pricing of EHB benefits not currently offered by FHP
- Calculation of FHP risk scores with data submitted to DFS
- Milliman age/gender factors as well as average members per contract
- Industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state

I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will certainly vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population and other such factors.

25. Actuarial Certification

I, [redacted] am a member of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.

I certify that:

(1) The submission is in compliance with all applicable laws and regulations of the State of New York, as well as Federal Statutes and Regulations (45 CFR 156.80(d)(1));

(2) The projected index rate is:
   a. Developed in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
      - ASOP No. 5, Incurred Health and Disability Claims
      - ASOP No. 8, Regulatory Filings for Health Plan Entities
      - ASOP No. 12, Risk Classification
      - ASOP No. 23, Data Quality
      - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
      - ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
      - ASOP No. 41, Actuarial Communications
   b. Reasonable in relation to the benefits provided and the population anticipated to be covered
   c. Neither excessive nor deficient

(3) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;

(4) The rates are not unfairly discriminatory.

(5) The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

(6) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

(7) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

Please note that the Part I Unified Rate Review Template does not demonstrate the process used by Healthfirst to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

[redacted] _____ ___June 12, 2014_____

[redacted] Date

Appendix A

Market-wide Index Rate Adjustments

Line	Adjustments	Adjustment Factor
11	Average Pricing Actuarial Value reflected in experience period	1.126
13	Impact of adjusting experience period data to EHB benefit level	1.064
14	Market wide adjustment for changes in provider network	0.991
15	Market wide adjustment for fee schedule changes	1.384
16	Market wide adjustment for utilization management changes	1.000
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives	1.000
18	Impact on risk pool of changes in expected covered membership risk characteristics	1.150
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by the standard rating regions	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	0.995
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.943
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000
24	Claim trend projection factor (midpoint of experience period to mid-point of rate applicability period)	1.157
25	Other 1 - Covered Lives Assessment	1.056
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.924**

Appendix B

Quality and Cost Containment Strategy for Healthfirst Individual On and Off Exchange Plans

A. Improving Health Outcomes

Healthfirst implements health promotion and care management programs to contribute in a meaningful way to improved health outcomes for our members. The objective of these programs is to increase member access to and engagement with preventive health services, especially the patient-centered medical home, to promote appropriate utilization of services for acute and chronic care and to optimize member capability for self-management and collaboration with the provider's care and treatment strategies.

Preventive Health: Member Access and Engagement

Upon enrollment, Healthfirst offers information and support in establishing primary care as well as the opportunity for incoming members to complete a health risk assessment (HRA). Based on the member's self-reported information, the member's evidence based prevention needs, and feedback from the member's primary care and other providers, Healthfirst provides members with targeted health information, health promotion and care management outreach, education and case management programs. For example, at the Healthfirst Healthy Living website, members have access to information that can help them understand how they can best fulfill prevention needs like mammography and colon cancer screening.

Central to the initial engagement of members is the assistance that Healthfirst provides to members to schedule an appointment with their primary care provider as soon as possible following enrollment. Healthfirst Member Services is available to assist the member in contacting their primary care provider and making the first appointment.

Chronic Care Management: Promoting Self-Management and Adherence to Care / Care Compliance

Healthfirst works collaboratively with primary care, mental health and substance abuse and specialty practices to promote the delivery of evidence based care to our members living with chronic conditions using a three-pronged approach:

1) Promoting Health Knowledge and Self-Management: using a variety of approaches, Healthfirst reaches out to members to close gaps in knowledge about their conditions and critical adherence and self-management strategies. Members are educated on the importance of adhering to medications and recognizing potential adverse effects associated with their therapeutic regimens. Efforts are made to identify and manage potential barriers to therapy to minimize the potential of medication non-compliance. Materials are produced based on the needs of members identified through quality and utilization reports, as well as feedback from our members and providers. Examples include printed brochures, newsletters, targeted member letter and reminder campaigns.
2) Care Management: Based on the profile of disease prevalence and utilization patterns of our members, Healthfirst implements disease management programs and initiatives. Conditions

that may be addressed by our Spectrum case managers include: diabetes, asthma, schizophrenia and sickle cell anemia.

3) Patient centered medical home: Healthfirst supports physicians and clinicians in the medical home by providing opportunities to refer members with complex needs to case management, and by sharing care plans with the patient's key providers when there is a change in health status or as requested.

Provider Partnership and Collaboration

Healthfirst works closely and collaboratively with its primary care practices to meet the health needs of our members. Many of our primary care practices have met NCQA criteria for designation as a "patient centered medical home," or PCMH. Health outcome targets are defined no less than annually and shared with the Healthfirst provider network to create a shared agenda to improve health outcomes for our members. Tools to support providers in caring for and serving our members include:

- Provider clinical bulletins detailing pragmatic ways to promote evidenced based care and improved outcomes
- Provider Symposia, which allows Healthfirst providers to highlight and share their best practices
- Provider Partnership Practice meetings for Healthfirst care management, quality and network staff to provide interim reports with feedback on utilization and quality, as well as satisfaction and medication utilization and adherence

Monitoring and Performance Improvement

No less than quarterly, Healthfirst administrative and clinical teams as well as providers and member representatives meet to review care management and quality activity and outcomes. At these quality meetings, thresholds and targets for quality performance are approved, trends in health outcomes and plan performance are reviewed, recommendations are made and work plans are monitored. Clinical Performance and Care Management programs are initiated to close gaps in targeted health outcomes and to improve strategies for identifying and minimizing medication barriers, thus improving compliance and therapeutic outcomes.

B. Preventing Hospital Readmissions

Healthfirst members at high risk for poor health outcomes and / or challenges in navigating the health care delivery system are identified based on patterns of utilization, such as fewer than expected primary care visits, frequent inpatient admissions, readmissions within 30 days in a defined time period or presence of a condition that places them at high risk for readmission such as congestive heart failure. These members are enrolled in complex case management. They receive intensive outreach that includes a detailed assessment which forms the foundation for a comprehensive care plan to address the areas of need. Once outreach and assessment are complete, the case manager will offer

community based services to support high risk members, such as home visits, medication reconciliation and post discharge coaching and reminders. Whenever possible, Healthfirst case managers work closely with hospital discharge planners to ensure a safe hospital discharge. Healthfirst also collaborates with providers and community based organizations to identify regional strategies to address difficult psychosocial issues such as homelessness, mental health and substance abuse community programs and innovative strategies to address navigation and cultural barriers to effective health care.

Healthfirst offers primary care provider practices real time notice that their assigned members have been hospitalized to promote the implementation of practice care coordination, including early appointments for members post discharge. The Healthfirst primary care practices receive feedback about the types of emergency department visits, preventable admissions and readmissions that their population of members has experienced in the previous quarter and year.

C. Improving Patient Safety

Healthfirst has implemented three major approaches to improving the safety of our patients.

Medication Management

Healthfirst supports and promotes the use of electronic prescribing and medication reconciliation to reduce polypharmacy and improved communication between the patient, the pharmacist and the prescriber. Through our pharmacy benefit manager, Healthfirst utilizes all point of sale edits available to improve the likelihood that members receive an optimized medication regimen. Pharmacy alerts for recalls and other prescriber concerns are distributed via multiple modalities which may include the Healthfirst portal, mail and email. Patients are educated through our newsletter about safe use of pharmaceuticals.

Reducing Antibiotic Resistance

Healthfirst actively educates and monitors non evidence based use of antibiotics in primary care and other practices to reduce the likelihood of the development of antibiotic resistance in the communities that we serve. These efforts include a provider bulletin with patient education material and quality reports that monitor the use of antibiotics for patients with uncomplicated acute bronchitis and viral upper respiratory infections. Pharmacy data is also available to support these efforts. Healthfirst offers provider workshops to consider alternatives to antibiotic prescriptions as appropriate.

Quality Assurance Reviews

The Healthfirst Medical Management Department and medical directors investigate potential quality assurance issues as reported by members, providers or Healthfirst staff to determine specific areas of risk for poor health outcomes for our members. Trends in provider, practice or network performance are discussed, and when necessary Healthfirst requires corrective action plans to avoid recurrence of confirmed quality of care events.

D. Wellness and Health Promotion Activities

Healthfirst has a number of wellness and health promotion programs that seek to meaningfully improve health outcomes for our members by increasing member access to preventive health services, promoting appropriate utilization of services for acute and chronic care, and optimizing member health status.

Spectrum of Health

The Spectrum of Health program promotes health and wellness in collaboration with each member's primary care provider as well as a provider network comprised of clinical specialists and subspecialists that support the health goals of each target population of members. The Spectrum of Health process begins with an assessment of health risk and key determinants of member wellness, matching member needs with available resources and providing targeted education, alerts, reminders and assistance to facilitate members in navigating the health care delivery system.

The Spectrum of Health Program is outcomes focused, seeking to:

- Promote access to age and gender appropriate primary, secondary and tertiary prevention services
- Ensure that age and gender appropriate preventive milestones are met
- Facilitate control of chronic illness
- Optimize the functional status of members in the community

Spectrum of Health meets the targeted needs of beneficiaries by utilizing the following strategies:

- Population based education tools such as newsletters and web based information
- Targeted education, reminders and alerts based on the needs of subpopulations of members
- Provider based outreach, education, and support
- Community based outreach and education in collaboration with community based organizations with shared health promotion goals

Healthfirst continually evaluates and improves health promotion programming by collecting and analyzing performance data.

Provider Collaboration & Reporting

Healthfirst regularly collaborates with providers with the objective of meaningfully improving health outcomes for members. Communication occurs via telephone, on-site visits, relevant articles in newsletters and the web portal, provider clinical bulletins, and targeted mailings.

Key components of Healthfirst's provider reporting efforts include:

- Quality Report Cards: provider quality reports are posted on the Healthfirst provider web portal for concurrent review of status for QARR measures in comparison with HF targets
- Non-compliant Member Lists: lists of providers' measure-specific non-compliant members in their panel are posted to the provider web portal. Providers are encouraged to outreach members needing services (e.g., preventive screenings, recommended lab tests, communications on medication adherence) and schedule appointments to close gaps in care

Member Health Risk Assessment

Healthfirst seeks to engage members in their health by providing access to a member health risk assessment (HRA). Results of member HRAs are used to:

- Generate member care plans
- Identify members who qualify for Healthfirst wellness campaigns and care management programs
- Inform provider outreach and education campaigns

E. Reducing Health and Health Care Disparities

Healthfirst is a community-based health plan with established processes and programs to reduce health and healthcare disparities among its members.

Language Services

Healthfirst's member-facing staff is reflective of its diverse membership. Member Services representatives are available to speak to members in English, Spanish, Mandarin, Cantonese, Russian, and Korean. To serve members with other language preferences, Healthfirst uses a language line. Healthfirst continually evaluates use and performance of the language line to identify opportunities for improvement as well as emerging language needs.

Community Outreach

Healthfirst has seven community offices that are each fully staffed with representatives to answer questions. In addition to these community offices, Healthfirst also has mobile vans and tables set up in local hospitals, clinics, and other locations to serve members. Representatives are fluent in the languages commonly spoken in the surrounding communities and provide the following services for members:

- Renewing or re-certifying health insurance
- Providing information about the health services and benefits offered by Healthfirst
- Addressing general member questions or needs, such as changing Primary Doctor (PCP), changing address or other personal information, or requesting a new member ID card;
- Providing tips, brochures, and other information to help live a healthier life

- Linking members to other helpful community organizations

Healthfirst hosts and/or supports over 600 community events per year. Examples of events that Healthfirst has supported in the last year include:

- Health Literacy Events
- Health Fairs / Street Fairs
- Nutrition Workshop / Healthy Cooking Contest
- Breast Cancer / HIV / Blood Pressure / A1C Screenings
- Diabetes Prevention & Health Awareness Days
- Infant Immunization Events
- Men's Health Awareness Events
- Healthy Heart Day Events
- Healthy Kids & Baby Showers
- Chronic Care Workshops
- Physical Wellness and Exercise Workshops
- Brown Bag Workshops (Pharmacist review medications with attendees)
- World Health Day Events
- Gospel Health Fairs & Gospel Concerts
- Community Running Events
- Holiday celebrations (e.g., Lunar Chinese New Year, Three Kings Day, Dominican Heritage, Black History Month, Women's History Month, Veterans Day, Vaisakhi South Asian Festival).
- Family Day Events (NYCHA)

Cultural Competency Trainings

Healthfirst has a comprehensive cultural competency training program. The objective of this program is to support the organization in its aims to (1) deliver the highest-quality service to every member regardless of race, ethnicity, culture, or language proficiency and (2) eliminate racial/ethnic disparities in health care.

Healthfirst's Member Services department serves as the front line staff for member questions and concerns. All member services representatives participate in an interactive, instructor-led cultural sensitivity training when they are hired. In subsequent years, Member Services representatives are required to take an annual refresher course on cultural sensitivity.

In addition, all Healthfirst employees have access to several online training courses that focus on cultural competency. These courses include:

- Diversity Awareness (Second Edition)
- Diversity for Managers (Second Edition)
- Intercultural Business Etiquette (Second Edition)

- Communicating Across Cultures (Includes Simulation)
- Writing for a Global Audience

F. Behavioral Health Services

The behavioral health program provides a full continuum of care, utilizing acute inpatient services, partial hospitalization and intensive outpatient programs along with ambulatory outpatient care. The program is designed to assist members in finding the appropriate provider to meet their needs and to facilitate timely access to treatments and services including emergency, urgent and routine office care. Healthfirst is ready to work with members to determine a specific provider and, where necessary and desired, assist the member in obtaining an appointment.

The program includes diagnostic-specific programs such as intensive outpatient programs that target substance use and eating disorders. Healthfirst is exploring the potential use of services that make access easier for members such as the use of tele-mental health as a vehicle for those who have difficulty attending appointments in offices to receive care closer to or in their homes.

Members who have been hospitalized not only receive an agreed upon specific discharge plan but Healthfirst also provides support within the community during the initial post-hospital period to improve the potential success of connection to the next treatment component. These activities serve to increase the likelihood of the member maintaining and enhancing progress made in the hospital and also to decrease the risks of readmission.

Healthfirst recognizes that many of those suffering from a mental illness or substance use disorder also have significant physical illnesses and psychosocial issues such as homelessness, poverty and illiteracy. Through its care management program, Healthfirst provides case management, care coordination and navigation assistance to reduce gaps in care and disparity in outcomes by facilitating access to preventive care, treatment and support services. Healthfirst care managers with medical and behavioral health expertise work closely with members, families, providers, social service agencies and community based organizations to provide a unique, member-centric, integrated and holistic approach to care.

Appendix C

Exhibit 18 (DFS)

Appendix D

AV Calculator – Screen Shots

Appendix C

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Healthfirst PHSP, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Individuals On Exchange

Separate column for each plan design (on or off Exchange)

Line #	General							
1	Product*	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
2	Product ID*	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.620	0.620	0.707	0.707	0.707	0.791
5	AV Pricing Value (total, risk pool experience based)*	0.707	0.714	0.707	0.829	0.837	0.829	0.970
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Bronze with Dependent Age 26 & Dental, On-Exchange	Bronze with Dependent Age 29 & Dental, On-Exchange	Child-Only Bronze with Dental, On-Exchange	Silver with Dependent Age 26 & Dental, On-Exchange	Silver with Dependent Age 29 & Dental, On-Exchange	Child-Only Silver with Dental, On-Exchange	Gold with Dependent Age 26 & Dental, On-Exchange
8	HIOS Plan ID*	91237NY0020001	91237NY0020002	91237NY0020019	91237NY0020005	91237NY0020006	91237NY0020021	91237NY0020009
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate							
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	$226,797,009						
10B	Member-Months for Latest Experience Period	871467.773						
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	260.25						
11	Average Pricing Actuarial Value reflected in experience period	1.126						
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate	
13	Impact of adjusting experience period data to EHB benefit level	1.064
14	Market wide adjustment for changes in provider network **	0.991
15	Market wide adjustment for fee schedule changes **	1.384
16	Market wide adjustment for utilization management changes **	1.000
17	Market wide adustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics ** **	1.150
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Healthfirst PHSP, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Individuals On Exchange

Separate column for each plan design (on or off Exchange)

Line #	General							
1	Product*	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
2	Product ID*	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.620	0.620	0.707	0.707	0.707	0.791
5	AV Pricing Value (total, risk pool experience based)*	0.707	0.714	0.707	0.829	0.837	0.829	0.970
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000						
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	0.995						
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.943						
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000						
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.157						
25	Other 1 (specify)	1.056						
26	Other 2 (specify)	1.000						
27	Other 3 (specify)	1.000						
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
29	Pricing actuarial value (without induced demand factor) #	0.620	0.620	0.620	0.707	0.707	0.707	0.791
30	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.030	1.030	1.030	1.080
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.166	1.166	1.166	1.164	1.164	1.164	1.162
37	Profit/Contribution to surplus margins	1.020	1.020	1.020	1.020	1.020	1.020	1.020
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Healthfirst PHSP, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Individuals On Exchange

Separate column for each plan design (on or off Exchange)

Line #	General							
1	Product*	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
2	Product ID*	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.620	0.620	0.707	0.707	0.707	0.791
5	AV Pricing Value (total, risk pool experience based)*	0.707	0.714	0.707	0.829	0.837	0.829	0.970
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	Age 29 Rider	1.000	1.010	1.000	1.000	1.010	1.000	1.000
42	Non-Standard Plan Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**0.738**	**0.745**	**0.738**	**0.865**	**0.873**	**0.865**	**1.012**

Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**328.08**	**331.36**	**328.08**	**384.55**	**388.40**	**384.55**	**450.12**

Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
Gold	Gold	Platinum	Platinum	Platinum	Catastrophic	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
0.980	0.970	1.149	1.161	1.149	0.438	0.730	0.738	0.856	0.865	1.002	1.012	1.188	1.188
HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Gold with Dependent Age 29 & Dental, On-Exchange	Child-Only Gold with Dental, On-Exchange	Platinum with Dependent Age 26 & Dental, On-Exchange	Platinum with Dependent Age 29 & Dental, On-Exchange	Child-Only Platinum with Dental, On-Exchange	Catastrophic with Dependent Age 26 & Dental, On-Exchange	Bronze with Dependent Age 26 & Dental, On-Exchange, Non-standard	Bronze with Dependent Age 29 & Dental, On-Exchange, Non-standard	Silver with Dependent Age 26 & Dental, On-Exchange, Non-standard	Silver with Dependent Age 29 & Dental, On-Exchange, Non-standard	Gold with Dependent Age 26 & Dental, On-Exchange, Non-standard	Gold with Dependent Age 29 & Dental, On-Exchange, Non-standard	Platinum with Dependent Age 26 & Dental, On-Exchange, Non-standard	Platinum with Dependent Age 26 & Dental, On-Exchange, Non-standard
91237NY0020010	91237NY0020023	91237NY0020013	91237NY0020014	91237NY0020025	91237NY0020017	91237NY0020052	91237NY0020053	91237NY0020054	91237NY0020055	91237NY0020056	91237NY0020057	91237NY0020058	91237NY0020058
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

231.16	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**

Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
Gold	Gold	Platinum	Platinum	Platinum	Catastrophic	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
0.980	0.970	1.149	1.161	1.149	0.438	0.730	0.738	0.856	0.865	1.002	1.012	1.188	1.188

1.924	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**

0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
1.080	1.080	1.150	1.150	1.150	1.000	1.000	1.000	1.030	1.030	1.080	1.080	1.150	1.150
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.162	1.162	1.160	1.160	1.160	1.167	1.166	1.166	1.164	1.164	1.162	1.162	1.160	1.160
1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020
1.000	1.000	1.000	1.000	1.000	0.646	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
Gold	Gold	Platinum	Platinum	Platinum	Catastrophic	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
0.980	0.970	1.149	1.161	1.149	0.438	0.730	0.738	0.856	0.865	1.002	1.012	1.188	1.188
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.010	1.000	1.000	1.010	1.000	1.000	1.000	1.010	1.000	1.010	1.000	1.010	1.000	1.010
1.000	1.000	1.000	1.000	1.000	1.000	1.033	1.033	1.033	1.033	1.033	1.033	1.033	1.033
1.022	**1.012**	**1.200**	**1.212**	**1.200**	**0.457**	**0.762**	**0.770**	**0.894**	**0.903**	**1.046**	**1.056**	**1.240**	**1.252**

454.62	**450.12**	**533.44**	**538.77**	**533.44**	**203.20**	**339.01**	**342.40**	**397.37**	**401.34**	**465.12**	**469.77**	**551.22**	**556.73**

Appendix D

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑		
Specialist Visit	☐	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$35.00	☑	☑		
Skilled Nursing Facility	☐	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	96.28%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	93.75%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.12%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$5,500.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.69%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,200.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.99%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$250.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$75.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑		
Skilled Nursing Facility	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.83%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.66%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$1,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$20.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$20.00	☑	☑		
Skilled Nursing Facility	☐	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98.48%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.76%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$6.00	☑	☑		
Preferred Brand Drugs	☐	☐		$15.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$30.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.43%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.99%
Metal Tier:	Bronze

Catastrophic Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,600.00			
Coinsurance (%, Insurer's Cost Share)			100%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑	
# Visits (1-10):		3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.4%
Metal Tier:	Bronze

healthfirst

June 13, 2014

RE: Healthfirst PHSP, Inc. – Individual On- Exchange Plans

We have prepared the enclosed submission, pursuant to section 4308(c) of the New York Insurance Law for Individual On-Exchange rates to be effective on January 1, 2015. The rates are for the New York City region which includes Bronx, Kings, New York, Queens, and Richmond Counties; and the Long Island region which includes Nassau and Suffolk Counties.

If you have any questions concerning this submission, please feel free to contact me at .

Sincerely,

cc: Mr. John Powell, Director of Rate Review, NYS DFS

Confidential and Proprietary

Healthfirst PHSP, Inc.

Part III Actuarial Memorandum

Individual Rate Filing

On-Exchange

Effective January 1, 2015

TABLE OF CONTENTS

1. GENERAL INFORMATION 1
2. PROPOSED RATE INCREASE(S) 2
3. EXPERIENCE PERIOD PREMIUM AND CLAIMS 2
4. BENEFIT CATEGORIES 3
5. PROJECTION FACTORS 3
6. CREDIBILITY MANUAL RATE DEVELOPMENT 3
7. CREDIBILITY OF EXPERIENCE 5
8. PAID TO ALLOWED RATIO 6
9. RISK ADJUSTMENT AND REINSURANCE 6
10. NON-BENEFIT EXPENSES AND PROFIT & RISK 7
11. PROJECTED LOSS RATIO 9
12. SINGLE RISK POOL 9
13. INDEX RATE 9
14. MARKET ADJUSTED INDEX RATES 9
15. PLAN ADJUSTED INDEX RATES 10
16. CALIBRATION 11
17. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT 11
18. AV METAL VALUES 12
19. AV PRICING VALUES 12
20. MEMBERSHIP PROJECTIONS 12
21. TERMINATED PRODUCTS 13
22. PLAN TYPE 13
23. WARNING ALERTS 13
24. RELIANCE 14
25. ACTUARIAL CERTIFICATION 14

1. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Healthfirst PHSP, Inc. (Healthfirst) rate filing, for the Individual block of business with an effective date of January 1, 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This memorandum is intended for use by the New York Department of Financial Services (DFS), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Healthfirst's Individual rate filing. The memorandum contains information that is confidential and proprietary to Healthfirst; therefore, the memorandum should not be distributed to any other parties unless required by law.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons including population changes, claims experience, and other deviations from assumptions.

Company Identifying Information

- Company Legal Name: Healthfirst PHSP, Inc.
- State: New York
- HIOS Issuer ID: [redacted]
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

2. Proposed Rate Increase(s)

Healthfirst is proposing an overall 9.8% rate decrease for their existing plans. The rate decrease varies by plan as shown in Worksheet 2 of the URRT. The proposed rates are effective January 1, 2015.

Note the following plan changes in 2015:

- Healthfirst is adding the following plans that offer non-standard Adult Dental and Vision benefits.

Benefit Design	HIOS Plan ID	On/Off Exchange	Metal Tier Level
Bronze with Dependent Age 26 & Dental, On-Exchange, Non-standard	91237NY0020052	On Exchange	Bronze
Bronze with Dependent Age 29 & Dental, On-Exchange, Non-standard	91237NY0020053	On Exchange	Bronze
Silver with Dependent Age 26 & Dental, On-Exchange, Non-standard	91237NY0020054	On Exchange	Silver
Silver with Dependent Age 29 & Dental, On-Exchange, Non-standard	91237NY0020055	On Exchange	Silver
Gold with Dependent Age 26 & Dental, On-Exchange, Non-standard	91237NY0020056	On Exchange	Gold
Gold with Dependent Age 29 & Dental, On-Exchange, Non-standard	91237NY0020057	On Exchange	Gold
Platinum with Dependent Age 26 & Dental, On-Exchange, Non-standard	91237NY0020058	On Exchange	Platinum
Platinum with Dependent Age 29 & Dental, On-Exchange, Non-standard	91237NY0020059	On Exchange	Platinum

Reason for Rate Changes

The major contributors to the rate changes include lower than expected claim trend, changes in network utilization, changes in benefits, changes in expected enrollment demographics, and changes in the reinsurance fees and parameters, all of which are discussed in more detail throughout this filing.

3. Experience Period Premium and Claims

Paid through Date

Healthfirst did not offer Individual insurance in 2013; therefore, no experience is populated in Worksheet 1. The rates were developed based upon 100% manual rates, as described below in the Credibility Manual Rate Development section.

Premiums (net of MLR Rebate) in Experience Period

Not applicable. No experience to report.

Allowed and Paid Claims Incurred During the Experience Period

Not applicable. No experience to report.

4. Benefit Categories

The services included in each benefit category of the URRT are consistent with the definitions of the benefit categories included in the URRT instructions. The "Other Medical" category includes home health care, ambulance, DME/ prosthetics, glasses/contacts, and pediatric dental services.

5. Projection Factors

Not applicable. Healthfirst did not have experience during the base period. See the Credibility Manual Rate Development section, just below, for a discussion of the projection factors.

6. Credibility Manual Rate Development -

Source and Appropriateness of Data Used

The manual rate was developed based on Healthfirst's Family Health Plus (FHP) experience for claims incurred in CY 2013 and paid through February 28, 2014. The FHP experience represents 72,000 members which is made up of 55,000 Healthfirst FHP members and 17,000 Neighborhood Health Plan (NHP) FHP members. Healthfirst acquired NHP in 2013 and only seven months of incurred data from June 1, 2013 to December 31, 2013 was available for NHP under Healthfirst contracts. CY 2013 was estimated based on extrapolating the seven months of available data.

The FHP experience was projected to 2015, and adjusted to reflect the changes from the FHP experience to that with which is expected under the Individual product. The factors include changes in provider reimbursement, in and out-of-network utilization, benefits, benefit richness, an adjustment for the Cost Sharing Reduction (CSR) plans, a population change factor and pent-up demand. The adjustments are discussed in detail below.

A corresponding HHS risk score was calculated using this same data in order to have consistency between the claims and the risk score used in the rate development. For NHP, 12 months of diagnoses data was available to calculate a risk score.

Adjustments Made to the Data

The following adjustments were made to the starting FHP data discussed above. Each one of these factors is included in Exhibit 18 required by New York State. For your review, we have included the market-wide adjustments from Exhibit 18 in **Appendix A** and have identified the line numbers from Exhibit 18 that reference the adjustments discussed below.

- Paid-to-Allowed and Induced Utilization (*Line 11*) – The starting FHP data is on a paid basis, and was adjusted to an allowed PMPM using a paid-to-allowed ratio of 0.979, based on the FHP experience. The starting data was also adjusted to remove the induced utilization that corresponds to experience with a paid-to-allowed ratio of 0.979. The induced utilization factor is 1.15, and was based on the HHS induced utilization factors. The combination of these factors produces the AV Pricing Value of 1.126 on Line 11.

- Benefits (*Line 13*) – It was assumed that the additional Essential Health Benefits (EHBs) covered under ACA would represent a cost increase of approximately 6.4% over current FHP benefits.

- Provider Network (*Line 14*) – Healthfirst's QHP network represents more than 90% of our current FHP network. The 'Market wide adjustment for changes in provider network' of 0.991 represents the impact of this slightly narrower network.

- Provider Reimbursement and Out-of-Network (OON) Utilization (*Line 15*) – Please note that the Provider Reimbursement adjustment and Out-of-Network Utilization adjustment were combined as "Market wide adjustment for fee schedule changes" in Exhibit 18. The adjustment factor is calculated as (1.197 x 1.156 = 1.384). Each component is discussed below:

  - Provider Reimbursement – The FHP reimbursement levels were increased by [redacted] to adjust the base period experience to reflect Healthfirst's expected reimbursement levels in 2015 for the individual product.

  - Out-of-Network (OON) Utilization – FHP experience reflects minimal OON utilization. Based on Healthfirst's emerging 2014 individual experience, we are expecting significantly more OON utilization, as well as higher OON reimbursement rates, compared to our base FHP experience. To reflect these changes, the experience was increased by 15.6%.

- Utilization Management; Quality Improvement and Cost Containment Adjustment (*Lines 16 and 17*) – There are no specific changes to our utilization management, quality improvement, and cost containment initiatives for our QHP programs compared to FHP PHSP. Hence, no adjustment was made to our base experience.

- Impact on Risk Pool of Changes in Expected Covered Membership Risk Characteristics (Line 18). Please note that the Population Change, CSR adjustment, and Pent-up Demand were combined in Line 18 of Exhibit 18, and are discussed below. The adjustment factor is calculated as (1.046 x 1.076 x 1.022 = 1.150)

  - Population Change – A population adjustment was made to the manual rate to reflect differences in the enrollment mix by age and gender between the FHP population and the individual population expected to enroll with Healthfirst in 2015. The adjustment was based on age/gender factors from the Milliman Health Cost Guidelines, and reflects expected differences between the average age/gender of the FHP population used for our base experience and the population expected to enroll in the individual product. The population change adjustment factor is 1.046.

- CSR Adjustment – The 7.6% adjustment reflects the additional utilization expected for the members enrolled in the CSR plans, due to their lower cost sharing. The HHS CSR factors were used to calculate an average CSR load which was then applied to all plans.

- Pent-up Demand – A 2.2% factor was applied to the base experience to reflect the expected first year additional cost due to pent-up demand from members enrolling in the individual product who were previously uninsured. We assumed that the previously uninsured new enrollment, roughly 22% of the total enrollment, will use 10% more services.

- Federal Risk Adjustment (Line 21) – Healthfirst is expecting a minimal risk transfer payment, which is discussed in more detail in Section 9 below. This equates to reducing the experience slightly by 0.5% (applying a factor of 0.995).

- Federal Transitional Reinsurance Program Recovery (Line 22) – The impact of the reinsurance program was estimated to be a 6% reduction to net claims prior to the covered lives assessment, or 5.7% after the covered lives assessment.

- Trend (Line 24) – An annual trend of 7.6% was assumed. The trend was based on our review of our historical FHP trends as well as projected industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state. The factor of 1.157 represents trends for a 24-month period.

- Covered Lives Assessment (Line 25) – Covered Lives Assessment is added to the base FHP medical expenses. Our estimates were based on the following:

  - 2014 Covered Lives Assessments were used since they are the latest published assessments. New York City assessments of $197.69 per Individual contract per year and $652.39 per Family contract were used; Long island assessments of $61.96 per Individual contract and $204.48 per Family contract were used.
  - An estimated 90% of our contracts would be in New York City based on our current membership distribution.
  - Using a tier distribution (that will be described in Section 17.B. “Conversion Factor”), the per-contract per year assessment was determined to be $376.91, or $18.72 PMPM. This equates to an adjustment factor of 1.056.

Inclusion of Capitation Payments

No capitated arrangements were included in the manual rate development.

7. Credibility of Experience

Since Healthfirst did not start offering Individual policies until 2014, we did not include any experience in the experience section of the URRT. Our results are based entirely on the manual rate. The experience section of the URRT was populated with 1's and 0's to allow for finalization.

8. Paid to Allowed Ratio

Average paid-to-allowed ratios by plan were developed using the HHS Actuarial Value Calculator. The ratios by metallic level are as follows:

Metallic Level	Paid to Allowed Ratio
Platinum	0.881
Gold	0.791
Silver	0.707
Bronze	0.620
Catastrophic	0.594

9. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

- An average HHS risk score was developed for the individual population using diagnoses and enrollment data consistent with the FHP data that was described in the development of the manual rate. To reflect Healthfirst's expected 2015 individual membership, the HHS risk score was adjusted to reflect projected 2015 AVs by metal level and CSR variation as well as the population factor discussed in Section 6 above.

- The statewide HHS risk score was developed using a blend of data published by DFS for the 2013 individual market (67%) and 2013 MarketScan© commercial data for New York (33%), adjusted to reflect the anticipated 2015 mix of plans by metal level and CSR variation.

- The statewide premium reflects a blend of the same populations used to develop the statewide risk score.

- The calculation of the risk transfer amount was based on the prescribed methodology, and is summarized below.

Risk Transfer Calculation	
Risk Factors less Rating Factors	0.004
Projected Statewide Premium	$468.99
Risk Transfer Received / (Paid)	$1.74
Administrative Expense	$0.08
Net Risk Transfer Received / (Paid)	$1.66

The Healthfirst average risk level is projected to be slightly above the statewide average risk level for the metallic plans, leading to the receipt of a risk transfer amount by Healthfirst. The Healthfirst average risk level is projected to be comparable to the statewide average risk level for the catastrophic plans, leading to no risk transfer payment by Healthfirst.

The risk transfer amounts were allocated proportionally to all plans based on plan premium. The administrative expense PMPM of $0.08 was applied on a PMPM basis for all plans.

Projected ACA Reinsurance Recoveries Net of Reinsurance

Reinsurance recoveries were estimated to be 6.0% of net claims cost, or $20.12 PMPM, based on DFS's estimate.

Anticipated reinsurance revenue is allocated proportionally based on plan premiums for all plans within a risk pool by applying the reinsurance adjustment factor as a constant multiplicative factor across all plans. The Transitional Reinsurance Program Fee of $3.67 PMPM was used for all plans, and was included in our administrative expenses.

10. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

Healthfirst's utilized an allocation methodology that distributes departmental costs using driver-based allocation, for example, membership, number of claims, number of calls, premium revenue, etc. We also distinguish departments between "fixed and variable" depending on the impact of membership growth on staffing levels. For example, Claims is considered a variable department since claims volume varies proportionately by membership. On the other hand, Finance Corporate, for example, is a department unaffected by membership growth for the most part.

Exchange administrative projections were driven by two main components – Projected 2015 membership, premium revenue and medical costs under our On-Exchange products were used to drive cost allocations for "variable" departments while a "current run-rate" PMPM was used to drive "fixed" departments, with nominal inflation.

Our administrative costs for all our On-Exchange QHP line of business include the following:

- Healthfirst Management Services, LLC (HFMS) will be contracted at twelve percent of premium for all the administrative activities of the PHSP QHP products. This will include, but not limited to, marketing and sales, enrollment, claims administration, medical management, member services, network management, product management, clinical and quality performance management, compliance, legal, regulatory, finance and actuarial. This fee will not include the taxes and fees described below.

- This includes the quality improvement/cost containment programs that impact the health plans, estimated at 0.62% of premium. Please refer to **Appendix B** for a description of all quality improvement/cost containment programs that impact the health plans included in the risk pool. This should tie in with the activities that improve health care quality, as specified in Exhibit 19 (DFS), the HHS MLR report and the Supplemental Health Care Exhibit.

The percentage load was applied to all plans.

Profit (or Contribution to Surplus) & Risk Margin

Profit or Contribution to Surplus margin of 2% was included in all plans. This is consistent with our current ROI for other products. Healthfirst recognizes the need to have positive margins on our programs. We believe that our 2.0% operating margin would provide necessary capital to invest in the company's infrastructure, provide adequate capital to meet reserve requirements for Healthfirst, and provide high quality care to our members.

The ROI for Healthfirst's investment portfolio in calendar years 2009 through 2013 are as follows:

Year	Total Rate of Return
2013	0.01%
2012	1.76%
2011	0.68%
2010	2.98%
2009	5.10%

The average ROI for the last five years was 2.11% for Healthfirst PHSP.

Taxes and Fees

The following taxes and fees are included in the premium rates:

- Patient-Centered Outcomes Research (PCORI) Tax of $2.00 per member per year;
- Transitional Reinsurance Program Fee of $3.67 PMPM;
- Risk Adjustment User Fee of $0.08 PMPM;
- New York State 332 Assessment estimated to be approximately 0.78% of premium;
- Health Insurance Excise Tax (ACA Premium Tax) is not included. Healthfirst is exempt in 2015 since
    i. It is incorporated as a nonprofit corporation under state law;
    ii. No part of the entity's profits inure to any private shareholder or individual, no substantial part of its activities include carrying on propaganda or otherwise attempting to influence legislation, and does not participate in or intervene in any

political campaign on behalf of or in opposition to any candidate for public office, and

iii. More than 80% of the entity's gross revenues are received from government programs that target low income, disabled or elderly populations.

- As a non-profit organization, Healthfirst does not pay any other State or Federal taxes or assessments.
- Since New York has determined that there will be no Exchange user fee for 2015, no adjustment was incorporated in our 2015 rates.

11. Projected Loss Ratio

Two loss ratios are calculated, one consistent with the New York State prescribed Medical Loss Ratio (MLR) methodology and one based on the Federal definition. The anticipated New York MLR is 84.2% relative to total premium, which exceeds the minimum allowable MLR of 82%. The anticipated Federal MLR is 86.4%, prior to credibility, which exceeds the Federal minimum MLR of 80%.

12. Single Risk Pool

Premium rates were not developed from historical experience as Healthfirst did not sell individual policies until January 2014.

13. Index Rate

The index rate was developed using the manual rate projection that was described in Section 6. The index rate is shown in Worksheet 1 of the URRT. The index rate reflects the estimated allowed claims cost PMPM for EHBs, prior to any adjustments for risk transfer or reinsurance.

14. Market Adjusted Index Rates

The Market Adjusted Index rate is calculated as the Index Rate adjusted for allowable market-wide adjustments. The market-wide adjustments are the net risk adjustment, the net federal reinsurance program costs, and the Exchange user fee, which are discussed in Sections 9 and 10 above. The Exchange user fee is $0.00 in New York State. The following table shows the calculation of Healthfirst's Market Adjusted Index Rate:

Market Adjusted Index Rate	
Index Rate	$482.23
Net Risk Adjustment	($1.66)
Net Transitional Reinsurance	($16.45)
Exchange Fee	0.00
Market Adjusted Index Rate	$464.12

15. Plan Adjusted Index Rates

The Plan Adjusted Index Rates are calculated in Exhibit 18 (**Appendix C**). Below is a description of the development. Although Healthfirst did not enter the individual market until 2014, New York State requires that the starting experience in the development of the individual rates be included in Exhibit 18. As discussed in Section 6 above, the starting experience is Healthfirst's CY 2013 FHP experience.

- Lines 10A – 12: Experience Period
  - Lines 10A – 10C: Shows the starting FHP net paid PMPM.
  - Lines 11 – 12: The FHP net paid PMPM is adjusted to an allowed PMPM level and adjusted to remove the induced utilization that is included in the starting experience, as discussed in Section 6 above.
- Lines 13 - 28: Market Wide Adjustments as discussed in detail in Section 6 above.
- Lines 29 – 43: Plan Level Adjustments.
  - The rate is adjusted for plan specific adjustments, as listed below and described earlier:
    - Pricing actuarial value
    - Induced Demand
    - Administrative expenses
    - Profit
    - Catastrophic plans eligibility adjustment – The average age for members enrolled in the metal plans is expected to be much higher than the average age for members enrolled in the catastrophic plan due to the eligibility limits for the catastrophic plan. Therefore, the cost for the metal plans was increased slightly while the cost for the catastrophic plans was decreased to reflect the differences in the average age for each pool relative to the combined pool. The adjustments were developed using age/gender factors from the Milliman Health Cost Guidelines.
    - Age 29 Rider Adjustment: For applicable plans.
    - Non- Standard Plan Adjustments: Adult Dental and Adult Vision benefits were added for applicable plans.
- Line 44: Plan adjusted index rate.

16. Calibration

No rate calibration was needed.

17. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed based on the plan adjusted index rate, which is on a PMPM basis, adjusted to reflect the required rate for each contract type. It is the final premium rate per contract, and the same rates are used for both the New York City and Long Island rating areas.

A. Standard Rating Regions

Healthfirst participates in two of the eight standardized rating regions in New York State:

- New York – Our service area includes Bronx, Kings, New York, Queens and Richmond.
- Long Island – Our service area includes Nassau and Suffolk.

The area factors to be used for 2015 are as follows:

Region	Counties included	Area factor
New York City	Bronx, Kings, New York, Queens, Richmond	1.000
Long Island	Nassau, Suffolk	1.000

Please note that these area factors are to be applied to the Index Rates shown for each QHP plan.

We determined that the area factors for these two regions are the same, which is consistent with our rating approach for our other products including Individual HMO, Healthy New York products, as well as Child Health Plus products.

B. Conversion Factor

The final premium rates for Employee Only, Employee and Spouse, Employee and Child(ren) and Employee/Spouse/Child(ren) are based on census factors prescribed by DFS:

Census Tiers	Relativity
Single	1.000
Single + Spouse	2.000
Single + Child(ren)	1.700
Single + Spouse + Child(ren)	2.850
Child Only	0.412

For a Child Only plan that covers two children in a family, the premium rate would be twice the one child premium rate. For a Child Only plan that covers three or more children in a family, the premium rate would be three times the one child premium rate, consistent with HHS Regulations.

We assumed a tier distribution that is similar to that of our year-to-date QHP experience. The development of the conversion factor is shown in the table below:

Census Tiers	Contract Distribution	Cost Per Contract	Number Of Members Per Contract	Loading Factor
Single	73.1%	1.000	1.000	1.034
Single + Spouse	22.4%	2.000	2.000	2.067
Single + Child(ren)	1.4%	1.700	2.629	1.757
Single + Spouse + Child(ren)	1.9%	2.850	4.019	2.946
Child Only	1.2%	0.412	1.000	0.426
Total	100.0%	1.261	1.303	1.303

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based entirely on the Federal AV Calculator. No adjustments were needed for any benefits from those values produced by the AV calculator.

19. AV Pricing Values

The AV Pricing Value includes the impact of cost sharing, the utilization impact of the cost sharing, and other allowable plan specific adjustments to the index rate. Each of the plan specific adjustments can be seen in Exhibit 18. The utilization adjustments due to cost sharing are based on the HHS induced utilization factors, and do not include health status adjustments.

20. Membership Projections

The membership projections are based on a blend of the current Healthfirst FHP members expected to transition to the individual market, current 2014 Healthfirst Individual enrollment, and new enrollment with demographics similar to the current individual market. Membership by plan is shown on Worksheet 2 of the URRT.

We also assume that the proportion of enrollment in CSR plans is similar to our current membership distribution, shown in chart below:

Plans	% Membership

Plans	% Membership
Platinum	6.0%
Gold	4.2%
Silver 94	30.8%
Silver 87	33.0%
Silver 73	7.9%
Silver	7.0%
Bronze	11.1%
Catastrophic	0.1%
	100.0%

21. Terminated Products

Healthfirst is terminating products in 2014 that do not offer pediatric dental.

Benefit Design	HIOS Plan ID	On/Off Exchange	Metal Tier Level
Bronze with Dependent Age 26 No Dental	91237NY0020003	On Exchange	Bronze
Bronze with Dependent Age 29 No Dental	91237NY0020004	On Exchange	Bronze
Silver with Dependent Age 26 No Dental	91237NY0020007	On Exchange	Silver
Silver with Dependent Age 29 No Dental	91237NY0020008	On Exchange	Silver
Gold with Dependent Age 26 No Dental	91237NY0020011	On Exchange	Gold
Gold with Dependent Age 29 No Dental	91237NY0020012	On Exchange	Gold
Platinum with Dependent Age 26 No Dental	91237NY0020015	On Exchange	Platinum
Platinum with Dependent Age 29 No Dental	91237NY0020016	On Exchange	Platinum
Catastrophic with Dependent Age 26 No Dental	91237NY0020018	On Exchange	Catastrophic
Child-Only Bronze No Dental	91237NY0020020	On Exchange	Bronze
Child-Only Silver No Dental	91237NY0020022	On Exchange	Silver
Child-Only Gold No Dental	91237NY0020024	On Exchange	Gold
Child-Only Platinum No Dental	91237NY0020026	On Exchange	Platinum

22. Plan Type

The Plan types listed in the URRT accurately describe Healthfirst's plans.

23. Warning Alerts

The following validation warnings occurred when finalizing the URRT workbook.

- WARNING - Wksh 1 - Market Experience - Cell F18 - Must be > 0 if Allowed Claims (Cell F16) is greater than 0.
  - Explanation – HF had no membership in 2013. Failing to enter non-zero Allowed Claims in Cell F16 would result in a validation error ("ERROR - Wksh 1 - Market Experience - Cell F16 - (Allowed Claims) is required.").

24. Reliance

In the preparation of this filing, I relied upon data provided by Milliman including the following items:

- Pricing of EHB benefits not currently offered by FHP
- Calculation of FHP risk scores with data submitted to DFS
- Milliman age/gender factors as well as average members per contract
- Industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state

I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will certainly vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population and other such factors.

25. Actuarial Certification

I, [redacted] am a member of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.

I certify that:

(1) The submission is in compliance with all applicable laws and regulations of the State of New York, as well as Federal Statutes and Regulations (45 CFR 156.80(d)(1));

(2) The projected index rate is:
   a. Developed in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
      - ASOP No. 5, Incurred Health and Disability Claims
      - ASOP No. 8, Regulatory Filings for Health Plan Entities
      - ASOP No. 12, Risk Classification
      - ASOP No. 23, Data Quality
      - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
      - ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
      - ASOP No. 41, Actuarial Communications
   b. Reasonable in relation to the benefits provided and the population anticipated to be covered
   c. Neither excessive nor deficient

(3) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;

(4) The rates are not unfairly discriminatory.

(5) The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

(6) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

(7) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

Please note that the Part I Unified Rate Review Template does not demonstrate the process used by Healthfirst to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

[redacted]

June 12, 2014
Date

Appendix A

Market-wide Index Rate Adjustments

Line	Adjustments	Adjustment Factor
11	Average Pricing Actuarial Value reflected in experience period	1.126
13	Impact of adjusting experience period data to EHB benefit level	1.064
14	Market wide adjustment for changes in provider network	0.991
15	Market wide adjustment for fee schedule changes	1.384
16	Market wide adjustment for utilization management changes	1.000
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives	1.000
18	Impact on risk pool of changes in expected covered membership risk characteristics	1.150
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by the standard rating regions	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	0.995
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.943
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000
24	Claim trend projection factor (midpoint of experience period to mid-point of rate applicability period)	1.157
25	Other 1 - Covered Lives Assessment	1.056
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.924**

Appendix B

Quality and Cost Containment Strategy for Healthfirst Individual On and Off Exchange Plans

A. Improving Health Outcomes

Healthfirst implements health promotion and care management programs to contribute in a meaningful way to improved health outcomes for our members. The objective of these programs is to increase member access to and engagement with preventive health services, especially the patient-centered medical home, to promote appropriate utilization of services for acute and chronic care and to optimize member capability for self-management and collaboration with the provider's care and treatment strategies.

Preventive Health: Member Access and Engagement

Upon enrollment, Healthfirst offers information and support in establishing primary care as well as the opportunity for incoming members to complete a health risk assessment (HRA). Based on the member's self-reported information, the member's evidence based prevention needs, and feedback from the member's primary care and other providers, Healthfirst provides members with targeted health information, health promotion and care management outreach, education and case management programs. For example, at the Healthfirst Healthy Living website, members have access to information that can help them understand how they can best fulfill prevention needs like mammography and colon cancer screening.

Central to the initial engagement of members is the assistance that Healthfirst provides to members to schedule an appointment with their primary care provider as soon as possible following enrollment. Healthfirst Member Services is available to assist the member in contacting their primary care provider and making the first appointment.

Chronic Care Management: Promoting Self-Management and Adherence to Care / Care Compliance

Healthfirst works collaboratively with primary care, mental health and substance abuse and specialty practices to promote the delivery of evidence based care to our members living with chronic conditions using a three-pronged approach:

1) Promoting Health Knowledge and Self-Management: using a variety of approaches, Healthfirst reaches out to members to close gaps in knowledge about their conditions and critical adherence and self-management strategies. Members are educated on the importance of adhering to medications and recognizing potential adverse effects associated with their therapeutic regimens. Efforts are made to identify and manage potential barriers to therapy to minimize the potential of medication non-compliance. Materials are produced based on the needs of members identified through quality and utilization reports, as well as feedback from our members and providers. Examples include printed brochures, newsletters, targeted member letter and reminder campaigns.
2) Care Management: Based on the profile of disease prevalence and utilization patterns of our members, Healthfirst implements disease management programs and initiatives. Conditions

that may be addressed by our Spectrum case managers include: diabetes, asthma, schizophrenia and sickle cell anemia.

3) Patient centered medical home: Healthfirst supports physicians and clinicians in the medical home by providing opportunities to refer members with complex needs to case management, and by sharing care plans with the patient's key providers when there is a change in health status or as requested.

Provider Partnership and Collaboration

Healthfirst works closely and collaboratively with its primary care practices to meet the health needs of our members. Many of our primary care practices have met NCQA criteria for designation as a "patient centered medical home," or PCMH. Health outcome targets are defined no less than annually and shared with the Healthfirst provider network to create a shared agenda to improve health outcomes for our members. Tools to support providers in caring for and serving our members include:

- Provider clinical bulletins detailing pragmatic ways to promote evidenced based care and improved outcomes
- Provider Symposia, which allows Healthfirst providers to highlight and share their best practices
- Provider Partnership Practice meetings for Healthfirst care management, quality and network staff to provide interim reports with feedback on utilization and quality, as well as satisfaction and medication utilization and adherence

Monitoring and Performance Improvement

No less than quarterly, Healthfirst administrative and clinical teams as well as providers and member representatives meet to review care management and quality activity and outcomes. At these quality meetings, thresholds and targets for quality performance are approved, trends in health outcomes and plan performance are reviewed, recommendations are made and work plans are monitored. Clinical Performance and Care Management programs are initiated to close gaps in targeted health outcomes and to improve strategies for identifying and minimizing medication barriers, thus improving compliance and therapeutic outcomes.

B. Preventing Hospital Readmissions

Healthfirst members at high risk for poor health outcomes and / or challenges in navigating the health care delivery system are identified based on patterns of utilization, such as fewer than expected primary care visits, frequent inpatient admissions, readmissions within 30 days in a defined time period or presence of a condition that places them at high risk for readmission such as congestive heart failure. These members are enrolled in complex case management. They receive intensive outreach that includes a detailed assessment which forms the foundation for a comprehensive care plan to address the areas of need. Once outreach and assessment are complete, the case manager will offer

community based services to support high risk members, such as home visits, medication reconciliation and post discharge coaching and reminders. Whenever possible, Healthfirst case managers work closely with hospital discharge planners to ensure a safe hospital discharge. Healthfirst also collaborates with providers and community based organizations to identify regional strategies to address difficult psychosocial issues such as homelessness, mental health and substance abuse community programs and innovative strategies to address navigation and cultural barriers to effective health care.

Healthfirst offers primary care provider practices real time notice that their assigned members have been hospitalized to promote the implementation of practice care coordination, including early appointments for members post discharge. The Healthfirst primary care practices receive feedback about the types of emergency department visits, preventable admissions and readmissions that their population of members has experienced in the previous quarter and year.

C. Improving Patient Safety

Healthfirst has implemented three major approaches to improving the safety of our patients.

Medication Management

Healthfirst supports and promotes the use of electronic prescribing and medication reconciliation to reduce polypharmacy and improved communication between the patient, the pharmacist and the prescriber. Through our pharmacy benefit manager, Healthfirst utilizes all point of sale edits available to improve the likelihood that members receive an optimized medication regimen. Pharmacy alerts for recalls and other prescriber concerns are distributed via multiple modalities which may include the Healthfirst portal, mail and email. Patients are educated through our newsletter about safe use of pharmaceuticals.

Reducing Antibiotic Resistance

Healthfirst actively educates and monitors non evidence based use of antibiotics in primary care and other practices to reduce the likelihood of the development of antibiotic resistance in the communities that we serve. These efforts include a provider bulletin with patient education material and quality reports that monitor the use of antibiotics for patients with uncomplicated acute bronchitis and viral upper respiratory infections. Pharmacy data is also available to support these efforts. Healthfirst offers provider workshops to consider alternatives to antibiotic prescriptions as appropriate.

Quality Assurance Reviews

The Healthfirst Medical Management Department and medical directors investigate potential quality assurance issues as reported by members, providers or Healthfirst staff to determine specific areas of risk for poor health outcomes for our members. Trends in provider, practice or network performance are discussed, and when necessary Healthfirst requires corrective action plans to avoid recurrence of confirmed quality of care events.

D. Wellness and Health Promotion Activities

Healthfirst has a number of wellness and health promotion programs that seek to meaningfully improve health outcomes for our members by increasing member access to preventive health services, promoting appropriate utilization of services for acute and chronic care, and optimizing member health status.

Spectrum of Health

The Spectrum of Health program promotes health and wellness in collaboration with each member's primary care provider as well as a provider network comprised of clinical specialists and subspecialists that support the health goals of each target population of members. The Spectrum of Health process begins with an assessment of health risk and key determinants of member wellness, matching member needs with available resources and providing targeted education, alerts, reminders and assistance to facilitate members in navigating the health care delivery system.

The Spectrum of Health Program is outcomes focused, seeking to:

- Promote access to age and gender appropriate primary, secondary and tertiary prevention services
- Ensure that age and gender appropriate preventive milestones are met
- Facilitate control of chronic illness
- Optimize the functional status of members in the community

Spectrum of Health meets the targeted needs of beneficiaries by utilizing the following strategies:

- Population based education tools such as newsletters and web based information
- Targeted education, reminders and alerts based on the needs of subpopulations of members
- Provider based outreach, education, and support
- Community based outreach and education in collaboration with community based organizations with shared health promotion goals

Healthfirst continually evaluates and improves health promotion programming by collecting and analyzing performance data.

Provider Collaboration & Reporting

Healthfirst regularly collaborates with providers with the objective of meaningfully improving health outcomes for members. Communication occurs via telephone, on-site visits, relevant articles in newsletters and the web portal, provider clinical bulletins, and targeted mailings.

Key components of Healthfirst's provider reporting efforts include:

- Quality Report Cards: provider quality reports are posted on the Healthfirst provider web portal for concurrent review of status for QARR measures in comparison with HF targets
- Non-compliant Member Lists: lists of providers' measure-specific non-compliant members in their panel are posted to the provider web portal. Providers are encouraged to outreach members needing services (e.g., preventive screenings, recommended lab tests, communications on medication adherence) and schedule appointments to close gaps in care

Member Health Risk Assessment

Healthfirst seeks to engage members in their health by providing access to a member health risk assessment (HRA). Results of member HRAs are used to:

- Generate member care plans
- Identify members who qualify for Healthfirst wellness campaigns and care management programs
- Inform provider outreach and education campaigns

E. Reducing Health and Health Care Disparities

Healthfirst is a community-based health plan with established processes and programs to reduce health and healthcare disparities among its members.

Language Services

Healthfirst's member-facing staff is reflective of its diverse membership. Member Services representatives are available to speak to members in English, Spanish, Mandarin, Cantonese, Russian, and Korean. To serve members with other language preferences, Healthfirst uses a language line. Healthfirst continually evaluates use and performance of the language line to identify opportunities for improvement as well as emerging language needs.

Community Outreach

Healthfirst has seven community offices that are each fully staffed with representatives to answer questions. In addition to these community offices, Healthfirst also has mobile vans and tables set up in local hospitals, clinics, and other locations to serve members. Representatives are fluent in the languages commonly spoken in the surrounding communities and provide the following services for members:

- Renewing or re-certifying health insurance
- Providing information about the health services and benefits offered by Healthfirst
- Addressing general member questions or needs, such as changing Primary Doctor (PCP), changing address or other personal information, or requesting a new member ID card;
- Providing tips, brochures, and other information to help live a healthier life

- Linking members to other helpful community organizations

Healthfirst hosts and/or supports over 600 community events per year. Examples of events that Healthfirst has supported in the last year include:

- Health Literacy Events
- Health Fairs / Street Fairs
- Nutrition Workshop / Healthy Cooking Contest
- Breast Cancer / HIV / Blood Pressure / A1C Screenings
- Diabetes Prevention & Health Awareness Days
- Infant Immunization Events
- Men's Health Awareness Events
- Healthy Heart Day Events
- Healthy Kids & Baby Showers
- Chronic Care Workshops
- Physical Wellness and Exercise Workshops
- Brown Bag Workshops (Pharmacist review medications with attendees)
- World Health Day Events
- Gospel Health Fairs & Gospel Concerts
- Community Running Events
- Holiday celebrations (e.g., Lunar Chinese New Year, Three Kings Day, Dominican Heritage, Black History Month, Women's History Month, Veterans Day, Vaisakhi South Asian Festival).
- Family Day Events (NYCHA)

Cultural Competency Trainings

Healthfirst has a comprehensive cultural competency training program. The objective of this program is to support the organization in its aims to (1) deliver the highest-quality service to every member regardless of race, ethnicity, culture, or language proficiency and (2) eliminate racial/ethnic disparities in health care.

Healthfirst's Member Services department serves as the front line staff for member questions and concerns. All member services representatives participate in an interactive, instructor-led cultural sensitivity training when they are hired. In subsequent years, Member Services representatives are required to take an annual refresher course on cultural sensitivity.

In addition, all Healthfirst employees have access to several online training courses that focus on cultural competency. These courses include:

- Diversity Awareness (Second Edition)
- Diversity for Managers (Second Edition)
- Intercultural Business Etiquette (Second Edition)

- Communicating Across Cultures (Includes Simulation)
- Writing for a Global Audience

F. Behavioral Health Services

The behavioral health program provides a full continuum of care, utilizing acute inpatient services, partial hospitalization and intensive outpatient programs along with ambulatory outpatient care. The program is designed to assist members in finding the appropriate provider to meet their needs and to facilitate timely access to treatments and services including emergency, urgent and routine office care. Healthfirst is ready to work with members to determine a specific provider and, where necessary and desired, assist the member in obtaining an appointment.

The program includes diagnostic-specific programs such as intensive outpatient programs that target substance use and eating disorders. Healthfirst is exploring the potential use of services that make access easier for members such as the use of tele-mental health as a vehicle for those who have difficulty attending appointments in offices to receive care closer to or in their homes.

Members who have been hospitalized not only receive an agreed upon specific discharge plan but Healthfirst also provides support within the community during the initial post-hospital period to improve the potential success of connection to the next treatment component. These activities serve to increase the likelihood of the member maintaining and enhancing progress made in the hospital and also to decrease the risks of readmission.

Healthfirst recognizes that many of those suffering from a mental illness or substance use disorder also have significant physical illnesses and psychosocial issues such as homelessness, poverty and illiteracy. Through its care management program, Healthfirst provides case management, care coordination and navigation assistance to reduce gaps in care and disparity in outcomes by facilitating access to preventive care, treatment and support services. Healthfirst care managers with medical and behavioral health expertise work closely with members, families, providers, social service agencies and community based organizations to provide a unique, member-centric, integrated and holistic approach to care.

Appendix C

Exhibit 18 (DFS)

Appendix D

AV Calculator – Screen Shots

Appendix C

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Healthfirst PHSP, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Individuals On Exchange

Separate column for each plan design (on or off Exchange)

Line #	General							
1	Product*	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
2	Product ID*	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.620	0.620	0.707	0.707	0.707	0.791
5	AV Pricing Value (total, risk pool experience based)*	0.707	0.714	0.707	0.829	0.837	0.829	0.970
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Bronze with Dependent Age 26 & Dental, On-Exchange	Bronze with Dependent Age 29 & Dental, On-Exchange	Child-Only Bronze with Dental, On-Exchange	Silver with Dependent Age 26 & Dental, On-Exchange	Silver with Dependent Age 29 & Dental, On-Exchange	Child-Only Silver with Dental, On-Exchange	Gold with Dependent Age 26 & Dental, On-Exchange
8	HIOS Plan ID*	91237NY0020001	91237NY0020002	91237NY0020019	91237NY0020005	91237NY0020006	91237NY0020021	91237NY0020009
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate							
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	$226,797,009						
10B	Member-Months for Latest Experience Period	871467.773						
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	260.25						
11	Average Pricing Actuarial Value reflected in experience period	1.126						
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate	
13	Impact of adjusting experience period data to EHB benefit level	1.064
14	Market wide adjustment for changes in provider network **	0.991
15	Market wide adjustment for fee schedule changes **	1.384
16	Market wide adjustment for utilization management changes **	1.000
17	Market wide adustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics ** **	1.150
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Number: HLFT-129571607
Market Segment : Individuals On Exchange

Separate column for each plan design (on or off Exchange)

Line #	General							
1	Product*	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
2	Product ID*	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.620	0.620	0.707	0.707	0.707	0.791
5	AV Pricing Value (total, risk pool experience based)*	0.707	0.714	0.707	0.829	0.837	0.829	0.970
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000						
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	0.995						
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.943						
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000						
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.157						
25	Other 1 (specify)	1.056						
26	Other 2 (specify)	1.000						
27	Other 3 (specify)	1.000						
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments							
29	Pricing actuarial value (without induced demand factor) #	0.620	0.620	0.620	0.707	0.707	0.707	0.791
30	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.030	1.030	1.030	1.080
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.166	1.166	1.166	1.164	1.164	1.164	1.162
37	Profit/Contribution to surplus margins	1.020	1.020	1.020	1.020	1.020	1.020	1.020
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Healthfirst PHSP, Inc.
NAIC Code: 15071
SERFF Number: HLFT-129571607
Market Segment : Individuals On Exchange

Separate column for each plan design (on or off Exchange)

Line #	General							
1	Product*	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
2	Product ID*	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold
4	AV Metal Value (HHS Calculator)*	0.620	0.620	0.620	0.707	0.707	0.707	0.791
5	AV Pricing Value (total, risk pool experience based)*	0.707	0.714	0.707	0.829	0.837	0.829	0.970
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	Age 29 Rider	1.000	1.010	1.000	1.000	1.010	1.000	1.000
42	Non-Standard Plan Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**0.738**	**0.745**	**0.738**	**0.865**	**0.873**	**0.865**	**1.012**

Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**328.08**	**331.36**	**328.08**	**384.55**	**388.40**	**384.55**	**450.12**

Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
Gold	Gold	Platinum	Platinum	Platinum	Catastrophic	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
0.980	0.970	1.149	1.161	1.149	0.438	0.730	0.738	0.856	0.865	1.002	1.012	1.188	1.188
HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Gold with Dependent Age 29 & Dental, On-Exchange	Child-Only Gold with Dental, On-Exchange	Platinum with Dependent Age 26 & Dental, On-Exchange	Platinum with Dependent Age 29 & Dental, On-Exchange	Child-Only Platinum with Dental, On-Exchange	Catastrophic with Dependent Age 26 & Dental, On-Exchange	Bronze with Dependent Age 26 & Dental, On-Exchange, Non-standard	Bronze with Dependent Age 29 & Dental, On-Exchange, Non-standard	Silver with Dependent Age 26 & Dental, On-Exchange, Non-standard	Silver with Dependent Age 29 & Dental, On-Exchange, Non-standard	Gold with Dependent Age 26 & Dental, On-Exchange, Non-standard	Gold with Dependent Age 29 & Dental, On-Exchange, Non-standard	Platinum with Dependent Age 26 & Dental, On-Exchange, Non-standard	Platinum with Dependent Age 26 & Dental, On-Exchange, Non-standard
91237NY0020010	91237NY0020023	91237NY0020013	91237NY0020014	91237NY0020025	91237NY0020017	91237NY0020052	91237NY0020053	91237NY0020054	91237NY0020055	91237NY0020056	91237NY0020057	91237NY0020058	91237NY0020058
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

231.16	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**	**231.16**

Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
Gold	Gold	Platinum	Platinum	Platinum	Catastrophic	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
0.980	0.970	1.149	1.161	1.149	0.438	0.730	0.738	0.856	0.865	1.002	1.012	1.188	1.188

1.924	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**	**1.924**

0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
1.080	1.080	1.150	1.150	1.150	1.000	1.000	1.000	1.030	1.030	1.080	1.080	1.150	1.150
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.162	1.162	1.160	1.160	1.160	1.167	1.166	1.166	1.164	1.164	1.162	1.162	1.160	1.160
1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020
1.000	1.000	1.000	1.000	1.000	0.646	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual	Healthfirst HMO Individual
91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002	91237NY002
Gold	Gold	Platinum	Platinum	Platinum	Catastrophic	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
0.791	0.791	0.881	0.881	0.881	0.594	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
0.980	0.970	1.149	1.161	1.149	0.438	0.730	0.738	0.856	0.865	1.002	1.012	1.188	1.188
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.010	1.000	1.000	1.010	1.000	1.000	1.000	1.010	1.000	1.010	1.000	1.010	1.000	1.010
1.000	1.000	1.000	1.000	1.000	1.000	1.033	1.033	1.033	1.033	1.033	1.033	1.033	1.033
1.022	**1.012**	**1.200**	**1.212**	**1.200**	**0.457**	**0.762**	**0.770**	**0.894**	**0.903**	**1.046**	**1.056**	**1.240**	**1.252**

454.62	**450.12**	**533.44**	**538.77**	**533.44**	**203.20**	**339.01**	**342.40**	**397.37**	**401.34**	**465.12**	**469.77**	**551.22**	**556.73**

Appendix D

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑		
Specialist Visit	☐	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$35.00	☑	☑		
Skilled Nursing Facility	☐	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	96.28%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	93.75%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.12%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$5,500.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.69%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,200.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.57%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.34%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.99%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$250.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$75.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑		
Skilled Nursing Facility	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.83%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.66%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$1,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$20.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$20.00	☑	☑		
Skilled Nursing Facility	☐	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98.48%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.76%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$6.00	☑	☑		
Preferred Brand Drugs	☐	☐		$15.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$30.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.43%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.99%
Metal Tier:	Bronze

Catastrophic Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,600.00			
Coinsurance (%, Insurer's Cost Share)			100%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑	
# Visits (1-10):		3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.4%
Metal Tier:	Bronze

healthfirst

June 13, 2014

[redacted]

RE: Healthfirst PHSP, Inc. – Individual On-Exchange Plans
Submission Effective January 1, 2015
Rates and Forms Application

Dear [redacted]

Healthfirst PHSP, Inc. is pleased to submit its premium rates and forms for certification for participation in NY State of Health for an effective date of January 1, 2015. The standard products listed herein are existing products and are therefore being filed pursuant to section 4308(c) of the NY Insurance Law.

Enclosed please find the rate manual for this submission. Broker/agent commissions are not applied to these rates.

These rates and forms are for participation in New York, Richmond, Kings, Queens, Bronx, Nassau, and Suffolk Counties.

If you have any questions regarding this on-Exchange rates and forms submission please feel free to contact [redacted] or me at [redacted], respectively. Thank you for your time and consideration. We look forward to working with you and the New York State of Health.

[redacted]

HEALTHFIRST PHSP, INC.

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

On-Exchange Individual HMO Rates and Forms Submission

Effective January 1, 2015

TABLE OF CONTENTS

I. Individual On-Exchange Plan Rates **4**

- **A.** Rate Pages – Standard Plans **6**
- **B.** Rate Pages – Non-Standard Plans **8**
- **C.** Description of Rating Classes, Factors, and Premium Discounts **10**
- **D.** Rate Calculation Examples **11**
- **E.** Expected Loss Ratio(s) **12**

II. Description of Benefits, Types of Coverage, Limitations, Exclusions, Issue Limits, and Renewal Conditions **13**

- **A.** Healthfirst Platinum Standard Plan **14**
- **B.** Healthfirst Gold Standard Plan **24**
- **C.** Healthfirst Silver Standard Plan **34**
  - **i.** 100-150% FPL Silver CSR Standard Plan **44**
  - **ii.** 150-200% FPL Silver CSR Standard Plan **54**
  - **iii.** 200-250% FPL Silver CSR Standard Plan **64**
- **D.** Healthfirst Bronze Standard Plan **74**
- **E.** Healthfirst Catastrophic Standard Plan **84**
- **F.** Healthfirst Native American/Alaska Native CSR Standard Plan **94**
- **G.** Healthfirst Platinum Non-Standard Plan **103**
- **H.** Healthfirst Gold Non-Standard Plan **113**
- **I.** Healthfirst Silver Non-Standard Plan **123**
  - **i.** 100-150% FPL Silver CSR Non-Standard Plan **133**

ii. 150-200% FPL Silver CSR Non-Standard Plan……**143**

iii. 200-250% FPL Silver CSR Non-Standard Plan……**153**

J. Healthfirst Bronze Non-Standard Plan…… **163**

K. Healthfirst Native American/Alaska Native CSR Non-Standard Plan……. **173**

III. Underwriting Guidelines…….. **182**

SECTION I –

On-Exchange Individual HMO Plan Rates

Section I.A – Rate Pages: Standard Plans

HEALTHFIRST PHSP, INC.
ON-EXCHANGE INDIVIDUAL HMO STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, & SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES – STANDARD PLANS

PLAN NAME	Healthfirst Platinum Leaf	Healthfirst Gold Leaf	Healthfirst Silver Leaf	Healthfirst Bronze Leaf	Healthfirst Green Leaf
METAL LEVEL	Platinum	Gold	Silver	Bronze	Catastrophic
Single	$551.37	$465.25	$397.48	$339.11	$210.03
Single + spouse	$1,102.74	$930.50	$794.96	$678.21	$420.07
Single + child(ren)	$937.33	$790.93	$675.71	$576.48	$357.06
Single + spouse + child(ren)	$1,571.41	$1,325.97	$1,132.81	$966.45	$598.60

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf	Healthfirst Gold Leaf	Healthfirst Silver Leaf	Healthfirst Bronze Leaf	Healthfirst Green Leaf
HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDCC-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15	HF-CCSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15	HF-NoCSSOB-15
		HF-S150SOB-15		
		HF-S200SOB-15		
		HF-NoCSSOB-15		

Age 29 Rider (additional cost to the base premium rate)

PLAN NAME	Healthfirst Platinum Leaf	Healthfirst Gold Leaf	Healthfirst Silver Leaf	Healthfirst Bronze Leaf
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$5.51	$4.65	$3.97	$3.39
Single + spouse	$11.03	$9.31	$7.95	$6.78
Single + child(ren)	$9.37	$7.91	$6.76	$5.76
Single + spouse + child(ren)	$15.71	$13.26	$11.33	$9.66

HEALTHFIRST PHSP, INC.
ON-EXCHANGE INDIVIDUAL HMO STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, & SUFFOLK COUNTIES

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf	Healthfirst Gold Leaf	Healthfirst Silver Leaf	Healthfirst Bronze Leaf
HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDIND-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15
HF-A29R-15	HF-A29R-15	HF-S150SOB-15	HF-A29R-15
		HF-S200SOB-15	
		HF-NoCSSOB-15	
		HF-A29R-15	

Child-only

PLAN NAME	Healthfirst Platinum Leaf Child-Only	Healthfirst Gold Leaf Child-Only	Healthfirst Silver Leaf Child-Only	Healthfirst Bronze Leaf Child-Only
METAL LEVEL	Platinum	Gold	Silver	Bronze
One Child	$227.16	$191.68	$163.76	$139.71
Two Children	$454.32	$383.36	$327.52	$279.42
Three or More Children	$681.48	$575.04	$491.28	$419.13

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf Child-Only	Healthfirst Gold Leaf Child-Only	Healthfirst Silver Leaf Child-Only	Healthfirst Bronze Leaf Child-Only
HF-STDCO-15	HF-STDCO-15	HF-STDCO-15	HF-STDCO-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15
		HF-S150SOB-15	
		HF-S200SOB-15	
		HF-NoCSSOB-15	

Section I.B – Rate Pages: Non-Standard Plans

HEALTHFIRST PHSP, INC.
ON-EXCHANGE INDIVIDUAL HMO NON-STANDARD PLANS
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, & SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES: NON-STANDARD PLANS

PLAN NAME	Healthfirst Platinum Leaf Premier	Healthfirst Gold Leaf Premier	Healthfirst Silver Leaf Premier	Healthfirst Bronze Leaf Premier
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$569.75	$480.76	$410.72	$350.41
Single + spouse	$1,139.49	$961.51	$821.45	$700.81
Single + child(ren)	$968.57	$817.29	$698.23	$595.69
Single + spouse + child(ren)	$1,623.78	$1,370.16	$1,170.56	$998.66

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf Premier	Healthfirst Gold Leaf Premier	Healthfirst Silver Leaf Premier	Healthfirst Bronze Leaf Premier
HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDIND-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15
		HF-S150SOB-15	
		HF-S200SOB-15	
		HF-NoCSSOB-15	

Age 29 Rider (additional cost to the base premium rate)

PLAN NAME	Healthfirst Platinum Leaf Premier	Healthfirst Gold Leaf Premier	Healthfirst Silver Leaf Premier	Healthfirst Bronze Leaf Premier
METAL LEVEL	Platinum	Gold	Silver	Bronze
Single	$5.69	$4.80	$4.11	$3.50
Single + spouse	$11.39	$9.62	$8.21	$7.01
Single + child(ren)	$9.67	$8.17	$6.98	$5.96
Single + spouse + child(ren)	$16.24	$13.70	$11.70	$9.99

Form Numbers of policies to which these rates apply:

Healthfirst Platinum Leaf Premier	Healthfirst Gold Leaf Premier	Healthfirst Silver Leaf Premier	Healthfirst Bronze Leaf Premier
HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDIND-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-NoCSSOB-15	HF-NoCSSOB-15	HF-S100SOB-15	HF-NoCSSOB-15
HF-A29R-15	HF-A29R-15	HF-S150SOB-15	HF-A29R-15
		HF-S200SOB-15	
		HF-NoCSSOB-15	
		HF-A29R-15	

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, 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**

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

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

Section I.D – Rate Calculation Example

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 5-9 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 Queens County choosing the Gold Standard Plan, 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 6 and refer to the first table under the heading "Proposed HMO Premium Rates – Standard Plans." Next, the consumer would refer to the column labeled, "Healthfirst Gold Leaf" and cross-reference the row labeled, "Single + Child(ren)." The rate for this plan is $790.93 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 86.4%. The expected loss ratio under New York State's MLR methodology is 84.2%. 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

***Note**: the standard benefit plan grids apply to the plan name listed, as well as its corresponding child-only standard plan (listed in parenthesis).

Section II.A – Platinum Standard Plan Benefit Description

Healthfirst Platinum Leaf (and Healthfirst Platinum Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$0**	
Family	**$0**	
Out-of-Pocket Limit		
Individual	**$2,000**	
Family	**$4,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$15 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$35 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$35 Copayment**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$100 Copayment**	**No limit**
Emergency Department	**$100 Copayment** **Copayment / Coinsurance waived if Hospital admission**	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$35 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Chiropractic Services	$35 Copayment	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Specialist Office	$35 Copayment	No limit
Performed as Outpatient Hospital Services	$35 Copayment	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$15 Copayment	
Performed in a Freestanding Center or Specialist Office	$15 Copayment	

Setting		
Performed as Outpatient Hospital Services	$15 Copayment	
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 Procedures)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		
Performed in a PCP Office	$15 Copayment	No limit
Performed in Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Home Infusion Therapy	$15 Copayment	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$35 Copayment	No limit
Performed as Outpatient Hospital Services	$35 Copayment	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$500 Copayment per admission**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$15 Copayment**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$35 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$15 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment**	**No limit**
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 and 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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
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 and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$15 Copayment**	**No limit**
Diabetic Education	**$15 Copayment**	**No limit**
Durable Medical Equipment and Braces	**10% Coinsurance**	**Coverage for standard equipment only.**
External Hearing Aids	**10% Coinsurance**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**10% Coinsurance**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$500 Copayment per admission**	**210 Days per Plan Year**
Outpatient	**$15 Copayment**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**10% Coinsurance**	
Prosthetic Devices		
External	**10% Coinsurance**	**One prosthetic device, per limb, per lifetime**
Internal	**10% Coinsurance**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**$100 Copayment**	**No limit**

Bariatric Surgery	**$100 Copayment**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$500 Copayment per admission**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$500 Copayment per admission**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
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 and Intensive Outpatient Program Services)	**$15 Copayment**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions**	**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	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$30 Copayment**	**No limit**
Tier 3	**$60 Copayment**	**No limit**
Up to a 90-day supply for Maintenance Drugs		

Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$90 Copayment**	**No limit**
Tier 3	**$180 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$75 Copayment**	**No limit**
Tier 3	**$150 Copayment**	**No limit**
Enteral Formulas	**10% Coinsurance**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$15 Copayment**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$15 Copayment**	
Major Dental (Endodontics, Periodontics and	**$15 Copayment**	

Prosthodontics)		
Orthodontics	**$15 Copayment**	
Pediatric Vision Care		
Exams	**$15 Copayment**	**One Exam Per 12-Month Period**
Lenses and Frames	**10% Coinsurance**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**10% Coinsurance**	

Section II.B – Gold Standard Plan Benefit Description

Healthfirst Gold Leaf (and Healthfirst Gold Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$600**	
Family	**$1,200**	
Out-of-Pocket Limit		
Individual	**$4,000**	
Family	**$8,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$25 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$40 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$40 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$40 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$25 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in a Specialist Office	$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$25 Copayment after deductible	No limit
Chiropractic Services	$40 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in a Specialist Office	$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$40 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$25 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$25 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$25 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$25 Copayment after deductible	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	$25 Copayment after deductible	No limit
Performed in Specialist Office	$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$25 Copayment after deductible	No limit
Home Infusion Therapy	$25 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$40 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,000 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$40 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$25 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$25 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$25 Copayment after deductible**	**No limit**
Diabetic Education	**$25 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**20% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**20% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**20% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,000 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$25 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**20% Coinsurance after deductible**	
Prosthetic Devices		
External	**20% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**20% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,000 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,000 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,000 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$25 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$25 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**20% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$25 Copayment after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$25 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$25 Copayment after deductible**	
Orthodontics	**$25 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$25 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**20% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**20% Coinsurance after deductible**	

Section II.C – Silver Standard Plan Benefit Description

Healthfirst Silver Leaf (and Silver Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$2,000**	
· **Family**	**$4,000**	
Out-of-Pocket Limit		
· **Individual**	**$5,500**	
· **Family**	**$11,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$30 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$50 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$50 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$50 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Chiropractic Services	**$50 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$30 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office	**$30 Copayment after deductible**	

Setting		
Performed as Outpatient Hospital Services	$30 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment after deductible	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	$30 Copayment after deductible	No limit
Performed in Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Home Infusion Therapy	$30 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,500 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$50 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$30 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$30 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$30 Copayment after deductible**	**No limit**
Diabetic Education	**$30 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**30% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**30% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**30% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,500 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$30 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**30% Coinsurance after deductible**	
Prosthetic Devices		
External	**30% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**30% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,500 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,500 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,500 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$30 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$30 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**30% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$30 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$30 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$30 Copayment after deductible**	
Orthodontics	**$30 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$30 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**30% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**30% Coinsurance after deductible**	

Section II.C.i – Silver 100-150% FPL CSR Standard Plan Benefit Description

Healthfirst Silver Leaf CSR 100-150 (and Silver Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$0**	
· **Family**	**$0**	
Out-of-Pocket Limit		
· **Individual**	**$1,000**	
· **Family**	**$2,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$10 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$20 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$20 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$20 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$50 Copayment after deductible**	**No limit**
Emergency Department	**$50 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$25 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$10 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$10 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$10 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$10 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$10 Copayment after deductible**	**No limit**
Chiropractic Services	**$20 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$10 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$10 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office	**$10 Copayment after deductible**	

Setting		
Performed as Outpatient Hospital Services	$10 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$15 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$10 Copayment after deductible	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	$10 Copayment after deductible	No limit
Performed in Specialist Office	$10 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$10 Copayment after deductible	No limit
Home Infusion Therapy	$10 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$10 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$20 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$20 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$100 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$25 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$25 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$10 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$10 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$10 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$15 Copayment after deductible**	**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 and Other	**$20 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$25 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$25 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$25 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$25 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$25 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$10 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$10 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$10 Copayment after deductible**	**No limit**
Diabetic Education	**$10 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**5% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**5% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**5% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$100 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$10 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**5% Coinsurance after deductible**	
Prosthetic Devices		
External	**5% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**5% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$100 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$50 Copayment after deductible**	**No limit**
Bariatric Surgery	**$25 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$100 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$100 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$100 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$10 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$100 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$10 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$6 Copayment**	**No limit**
Tier 2	**$15 Copayment**	**No limit**
Tier 3	**$30 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$18 Copayment**	**No limit**
Tier 2	**$45 Copayment**	**No limit**
Tier 3	**$90 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$15 Copayment**	**No limit**
Tier 2	**$38 Copayment**	**No limit**
Tier 3	**$75 Copayment**	**No limit**
Enteral Formulas	**5% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$10 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$10 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$10 Copayment after deductible**	
Orthodontics	**$10 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$10 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**5% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**5% Coinsurance after deductible**	

Section II.C.ii – Silver 150-200% FPL CSR Standard Plan Benefit Description

Healthfirst Silver Leaf CSR 150-200 (and Silver Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$250**	
· **Family**	**$750**	
Out-of-Pocket Limit		
· **Individual**	**$2,000**	
· **Family**	**$4,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$15 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$35 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$35 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$35 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$75 Copayment after deductible**	**No limit**
Emergency Department	**$75 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$75 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$15 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$15 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$15 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment after deductible**	**No limit**
Chiropractic Services	**$35 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$15 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$15 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office	**$15 Copayment after deductible**	

Setting		
Performed as Outpatient Hospital Services	$15 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$15 Copayment after deductible	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	$15 Copayment after deductible	No limit
Performed in Specialist Office	$15 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$15 Copayment after deductible	No limit
Home Infusion Therapy	$15 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$15 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$35 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$35 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$250 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$75 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$75 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$15 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$15 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$25 Copayment after deductible**	**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 and Other	**$35 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$75 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$75 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$75 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$75 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$75 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$15 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$15 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$15 Copayment after deductible**	**No limit**
Diabetic Education	**$15 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**10% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**10% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**10% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$250 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$15 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**10% Coinsurance after deductible**	
Prosthetic Devices		
External	**10% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**10% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$250 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$75 Copayment after deductible**	**No limit**
Bariatric Surgery	**$75 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$250 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$250 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$250 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$15 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$250 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$15 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$9 Copayment**	**No limit**
Tier 2	**$20 Copayment**	**No limit**
Tier 3	**$40 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$27 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$23 Copayment**	**No limit**
Tier 2	**$50 Copayment**	**No limit**
Tier 3	**$100 Copayment**	**No limit**
Enteral Formulas	**10% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$15 Copayment after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$15 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$15 Copayment after deductible**	
Orthodontics	**$15 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$15 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**10% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**10% Coinsurance after deductible**	

Section II.C.iii – Silver 200-250% FPL CSR Standard Plan Benefit Description

Healthfirst Silver Leaf CSR 200-250 (and Silver Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$1,200**	
· **Family**	**$2,400**	
Out-of-Pocket Limit		
· **Individual**	**$5,200**	
· **Family**	**$10,400**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$30 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$50 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$50 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$50 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Chiropractic Services	$50 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$30 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$30 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$30 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment after deductible	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	$30 Copayment after deductible	No limit
Performed in Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Home Infusion Therapy	$30 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,500 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$50 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$30 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$30 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$30 Copayment after deductible**	**No limit**
Diabetic Education	**$30 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**25% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**25% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**25% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,500 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$30 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**25% Coinsurance after deductible**	
Prosthetic Devices		
External	**25% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**25% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,500 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,500 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**$1,500 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$30 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$30 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**25% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$30 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$30 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$30 Copayment after deductible**	
Orthodontics	**$30 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$30 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**25% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**25% Coinsurance after deductible**	

Section II.D – Bronze Standard Plan Benefit Description

Healthfirst Bronze Leaf (& Healthfirst Bronze Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$3,000**	
· **Family**	**$6,000**	
Out-of-Pocket Limit		
· **Individual**	**$6,350**	
· **Family**	**$12,700**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**50% Coinsurance after deductible**	**No limit**
Specialist Office Visits (or home visits)	**50% Coinsurance after deductible**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**50% Coinsurance after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**50% Coinsurance after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**50% Coinsurance after deductible**	**No limit**
Emergency Department	**50% Coinsurance after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**50% Coinsurance after deductible**	**No limit**
Anesthesia Services (all settings)	**50% Coinsurance after deductible**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Chiropractic Services	50% Coinsurance after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	50% Coinsurance after deductible	
Performed in a Freestanding Center or Specialist Office	50% Coinsurance after deductible	

Setting		
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	50% Coinsurance after deductible	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 after deductible	No limit
Performed in Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Home Infusion Therapy	50% Coinsurance after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	50% Coinsurance after deductible	No limit
Laboratory Procedures		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**50% Coinsurance after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**50% Coinsurance after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**50% Coinsurance after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**50% Coinsurance after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**50% Coinsurance after deductible**	**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 and Other	**50% Coinsurance after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**50% Coinsurance after deductible**	**No limit**
Inpatient Hospital Surgery	**50% Coinsurance after deductible**	**No limit**
Outpatient Hospital Surgery	**50% Coinsurance after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**50% Coinsurance after deductible**	**No limit**
Office Surgery	**50% Coinsurance after deductible**	**No limit**
Elective Termination of Pregnancy	**50% Coinsurance after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**50% Coinsurance after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**50% Coinsurance after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**50% Coinsurance after deductible**	**No limit**
Diabetic Education	**50% Coinsurance after deductible**	**No limit**
Durable Medical Equipment and Braces	**50% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**50% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**50% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**50% Coinsurance after deductible**	**210 Days per Plan Year**
Outpatient	**50% Coinsurance after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**50% Coinsurance after deductible**	
Prosthetic Devices		
External	**50% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**50% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**50% Coinsurance after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**50% Coinsurance after deductible**	**No limit**

Bariatric Surgery	**50% Coinsurance after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**50% Coinsurance after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**50% Coinsurance after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**50% Coinsurance after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**50% Coinsurance after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**50% Coinsurance after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**50% Coinsurance after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**
Up to a 90-day supply for Maintenance Drugs		

Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**50% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**50% Coinsurance after deductible**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**50% Coinsurance after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**50% Coinsurance after deductible**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**50% Coinsurance after deductible**	

Orthodontics	**50% Coinsurance after deductible**	
Pediatric Vision Care		
Exams	**50% Coinsurance after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**50% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**50% Coinsurance after deductible**	

Section II.E – Catastrophic Standard Plan Benefit Description

Healthfirst Green Leaf (& Healthfirst Green Leaf Child-Only) Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$6,600**	
· **Family**	**$13,200**	
Out-of-Pocket Limit		
· **Individual**	**$6,600**	
· **Family**	**$13,200**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**Covered in full after deductible**	**No limit**
Specialist Office Visits (or home visits)	**Covered in full after deductible**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full after deductible**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**Covered in full after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**Covered in full after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**Covered in full after deductible**	**No limit**
Emergency Department	**Covered in full after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**Covered in full after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full after deductible**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Covered in full after deductible**	**No limit**
Chemotherapy		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Chiropractic Services	**Covered in full after deductible**	**No limit**
Clinical Trials	**Covered in full after deductible**	
Diagnostic Testing		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**Covered in full after deductible**	
Performed in a Freestanding Center or Specialist Office Setting	**Covered in full after deductible**	
Performed as Outpatient	**Covered in full after deductible**	

Hospital Services		
Habilitation Services	**Covered in full after deductible**	**60 visits per condition, per lifetime combined therapies**
(Physical Therapy, Occupational Therapy or Speech Therapy)		
Home Health Care	**Covered in full after deductible**	**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	**Covered in full after deductible**	**No limit**
Performed in Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Home Infusion Therapy	**Covered in full after deductible**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**
Inpatient Hospital Services and Birthing Center	**Covered in full after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**

Physician Midwife Services for Delivery	**Covered in full after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**Covered in full after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**Covered in full after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full after deductible**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**Covered in full after deductible**	**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 and Other	**Covered in full after deductible**	**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		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.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	Covered in full after deductible	No limit
Inpatient Hospital Surgery	Covered in full after deductible	No limit
Outpatient Hospital Surgery	Covered in full after deductible	No limit
Surgery Performed at an Ambulatory Surgical Center	Covered in full after deductible	No limit
Office Surgery	Covered in full after deductible	No limit
Elective Termination of Pregnancy	Covered in full after deductible	1 Treatment per Year; Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	Covered in full after deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full after deductible	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a	Covered in full after deductible	No limit

90-day supply)		
Diabetic Education	**Covered in full after deductible**	**No limit**
Durable Medical Equipment and Braces	**Covered in full after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**Covered in full after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**Covered in full after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**Covered in full after deductible**	**210 Days per Plan Year**
Outpatient	**Covered in full after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**Covered in full after deductible**	
Prosthetic Devices		
External	**Covered in full after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**Covered in full after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**Covered in full after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**Covered in full after deductible**	**No limit**
Bariatric Surgery	**Covered in full after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**Covered in full after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and	**Covered in full after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**

Occupational therapy)		
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**Covered in full after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**Covered in full after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**Covered in full after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**Covered in full after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**Covered in full after deductible**	**No limit**
Tier 2	**Covered in full after deductible**	**No limit**
Tier 3	**Covered in full after deductible**	**No limit**
Up to a 90-day supply for Maintenance Drugs		
Tier 1	**Covered in full after deductible**	**No limit**
Tier 2	**Covered in full after deductible**	**No limit**
Tier 3	**Covered in full after deductible**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		

Tier 1	**Covered in full after deductible**	**No limit**
Tier 2	**Covered in full after deductible**	**No limit**
Tier 3	**Covered in full after deductible**	**No limit**
Enteral Formulas	**Covered in full after deductible**	**No limit**
Off Label Cancer Drugs	**Covered in full after deductible**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**Covered in full after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**Covered in full after deductible**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**Covered in full after deductible**	
Orthodontics	**Covered in full after deductible**	
Pediatric Vision Care		
Exams	**Covered in full after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**Covered in full after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**

Contact Lenses	**Covered in full after deductible**	

Section II.F – Native American/Alaska Native CSR Standard Plan Benefit Description

Healthfirst Native American/Alaskan Native CSR Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$0**	
· **Family**	**$0**	
Out-of-Pocket Limit		
· **Individual**	**$0**	
· **Family**	**$0**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**Covered in full**	**No limit**
Specialist Office Visits (or home visits)	**Covered in full**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**Covered in full**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**Covered in full**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**Covered in full**	**No limit**
Emergency Department	**Covered in full**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**Covered in full**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Performed as Inpatient Hospital Services	**Covered in full**	**No limit**
Chemotherapy		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Chiropractic Services	**Covered in full**	**No limit**
Clinical Trials	**Covered in full**	
Diagnostic Testing		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**Covered in full**	
Performed in a Freestanding Center or Specialist Office Setting	**Covered in full**	
Performed as Outpatient	**Covered in full**	

Hospital Services		
Habilitation Services	**Covered in full**	**60 visits per condition, per lifetime combined therapies**
(Physical Therapy, Occupational Therapy or Speech Therapy)		
Home Health Care	**Covered in full**	**40 Visits per Plan Year**
Infertility Services	**Covered in full**	**• Member must be between ages of 21 and 44** **• Advanced infertility not covered**
Infusion Therapy		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Home Infusion Therapy	**Covered in full**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**
Inpatient Hospital Services and Birthing Center	**Covered in full**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**

Physician Midwife Services for Delivery	**Covered in full**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**Covered in full**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**Covered in full**	**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 and Other	**Covered in full**	**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		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.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	Covered in full	No limit
Inpatient Hospital Surgery	Covered in full	No limit
Outpatient Hospital Surgery	Covered in full	No limit
Surgery Performed at an Ambulatory Surgical Center	Covered in full	No limit
Office Surgery	Covered in full	No limit
Elective Termination of Pregnancy	Covered in full	1 Treatment per Year; Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	Covered in full	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	Covered in full	No limit

Diabetic Education	**Covered in full**	**No limit**
Durable Medical Equipment and Braces	**Covered in full**	**Coverage for standard equipment only.**
External Hearing Aids	**Covered in full**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**Covered in full**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**Covered in full**	**210 Days per Plan Year**
Outpatient	**Covered in full**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**Covered in full**	
Prosthetic Devices		
External	**Covered in full**	**One prosthetic device, per limb, per lifetime**
Internal	**Covered in full**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**Covered in full. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**Covered in full**	**No limit**
Bariatric Surgery	**Covered in full**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**Covered in full**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**Covered in full**	**60 Consecutive Days Per Condition, Per Lifetime**

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**Covered in full. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**Covered in full**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**Covered in full Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**Covered in full**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**
Tier 3	**Covered in full**	**No limit**
Up to a 90-day supply for Maintenance Drugs		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**
Tier 3	**Covered in full**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**

Tier 3	**Covered in full**	**No limit**
Enteral Formulas	**Covered in full**	**No limit**
Off Label Cancer Drugs	**Covered in full**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**Covered in full**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**Covered in full**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**Covered in full**	
Orthodontics	**Covered in full**	
Pediatric Vision Care		
Exams	**Covered in full**	**One Exam Per 12-Month Period**
Lenses and Frames	**Covered in full**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**Covered in full**	

Section II.G – Platinum Non-Standard Plan Benefit Description

Healthfirst Platinum Leaf Premier Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$0**	
Family	**$0**	
Out-of-Pocket Limit		
Individual	**$2,000**	
Family	**$4,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$15 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$35 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$35 Copayment**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$100 Copayment**	**No limit**
Emergency Department	**$100 Copayment** **Copayment / Coinsurance waived if Hospital admission**	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$35 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Chiropractic Services	$35 Copayment	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Specialist Office	$35 Copayment	No limit
Performed as Outpatient Hospital Services	$35 Copayment	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$15 Copayment	
Performed in a Freestanding Center or Specialist Office	$15 Copayment	

Setting		
Performed as Outpatient Hospital Services	$15 Copayment	
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 Procedures)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		
Performed in a PCP Office	$15 Copayment	No limit
Performed in Specialist Office	$15 Copayment	No limit
Performed as Outpatient Hospital Services	$15 Copayment	No limit
Home Infusion Therapy	$15 Copayment	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$15 Copayment	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$35 Copayment	No limit
Performed as Outpatient Hospital Services	$35 Copayment	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$500 Copayment per admission**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$15 Copayment**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$35 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$15 Copayment**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment**	**No limit**
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 and 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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
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 and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$15 Copayment**	**No limit**
Diabetic Education	**$15 Copayment**	**No limit**
Durable Medical Equipment and Braces	**10% Coinsurance**	**Coverage for standard equipment only.**
External Hearing Aids	**10% Coinsurance**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**10% Coinsurance**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$500 Copayment per admission**	**210 Days per Plan Year**
Outpatient	**$15 Copayment**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**10% Coinsurance**	
Prosthetic Devices		
External	**10% Coinsurance**	**One prosthetic device, per limb, per lifetime**
Internal	**10% Coinsurance**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**$100 Copayment**	**No limit**

Bariatric Surgery	**$100 Copayment**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$500 Copayment per admission**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$500 Copayment per admission**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
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 and Intensive Outpatient Program Services)	**$15 Copayment**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions**	**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	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$30 Copayment**	**No limit**
Tier 3	**$60 Copayment**	**No limit**
Up to a 90-day supply for Maintenance Drugs		

Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$90 Copayment**	**No limit**
Tier 3	**$180 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$75 Copayment**	**No limit**
Tier 3	**$150 Copayment**	**No limit**
Enteral Formulas	**10% Coinsurance**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$15 Copayment**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$15 Copayment**	
Major Dental (Endodontics, Periodontics and	**$15 Copayment**	

Prosthodontics)		
Orthodontics	**$15 Copayment**	
Vision Care		
Exams	**$15 Copayment**	**One Exam Per 12-Month Period**
Lenses and Frames	**10% Coinsurance**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**10% Coinsurance**	

Section II.H – Gold Non-Standard Plan Benefit Description

Healthfirst Gold Leaf Premier Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$600**	
Family	**$1,200**	
Out-of-Pocket Limit		
Individual	**$4,000**	
Family	**$8,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$25 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$40 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**

Vasectomy	**$40 Copayment after deductible**	**No limit**
Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$40 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**

Anesthesia Services (all settings)	**Covered in full**	**No limit**
Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Chiropractic Services	**$40 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$25 Copayment after deductible**	

Performed in a Freestanding Center or Specialist Office Setting	**$25 Copayment after deductible**	
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	
Habilitation Services **(Physical Therapy, Occupational Therapy or Speech Therapy)**	**$30 Copayment after deductible**	**60 visits per condition, per lifetime combined therapies**
Home Health Care	**$25 Copayment after deductible**	**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	**$25 Copayment after deductible**	**No limit**
Performed in Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Home Infusion Therapy	**$25 Copayment after deductible**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**

Inpatient Hospital Services and Birthing Center	**$1,000 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$40 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$25 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$25 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$25 Copayment after deductible**	**No limit**
Diabetic Education	**$25 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**20% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**20% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**20% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,000 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$25 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**20% Coinsurance after deductible**	
Prosthetic Devices		
External	**20% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**20% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,000 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,000 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,000 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$25 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$25 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**20% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$25 Copayment after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$25 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$25 Copayment after deductible**	
Orthodontics	**$25 Copayment after deductible**	
Vision Care		
Exams	**$25 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**20% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**20% Coinsurance after deductible**	

Section II.I – Silver Non-Standard Plan Benefit Description

Healthfirst Silver Leaf Premier Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$2,000**	
· **Family**	**$4,000**	
Out-of-Pocket Limit		
· **Individual**	**$5,500**	
· **Family**	**$11,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$30 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$50 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$50 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$50 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Chiropractic Services	$50 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$30 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$30 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$30 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment after deductible	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	$30 Copayment after deductible	No limit
Performed in Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Home Infusion Therapy	$30 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,500 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$50 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$30 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$30 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$30 Copayment after deductible**	**No limit**
Diabetic Education	**$30 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**30% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**30% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**30% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,500 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$30 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**30% Coinsurance after deductible**	
Prosthetic Devices		
External	**30% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**30% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,500 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,500 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,500 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$30 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$30 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**30% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$30 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$30 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$30 Copayment after deductible**	
Orthodontics	**$30 Copayment after deductible**	
Vision Care		
Exams	**$30 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**30% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**30% Coinsurance after deductible**	

Section II.J – Silver 100-150% FPL Non-Standard Plan Benefit Description

Healthfirst Silver Leaf Premier CSR 100-150 Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$0**	
· **Family**	**$0**	
Out-of-Pocket Limit		
· **Individual**	**$1,000**	
· **Family**	**$2,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$10 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$20 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$20 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$20 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$50 Copayment after deductible**	**No limit**
Emergency Department	**$50 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$25 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$10 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$10 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$10 Copayment after deductible	No limit
Performed in a Specialist Office	$10 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$10 Copayment after deductible	No limit
Chiropractic Services	$20 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$10 Copayment after deductible	No limit
Performed in a Specialist Office	$20 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$20 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$10 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$10 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$10 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$15 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$10 Copayment after deductible	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	$10 Copayment after deductible	No limit
Performed in Specialist Office	$10 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$10 Copayment after deductible	No limit
Home Infusion Therapy	$10 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$10 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$20 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$20 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$100 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$25 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$25 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$10 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$20 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$20 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$10 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$10 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$15 Copayment after deductible**	**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 and Other	**$20 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$25 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$25 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$25 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$25 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$25 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$10 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$10 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$10 Copayment after deductible**	**No limit**
Diabetic Education	**$10 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**5% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**5% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**5% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$100 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$10 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**5% Coinsurance after deductible**	
Prosthetic Devices		
External	**5% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**5% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$100 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$50 Copayment after deductible**	**No limit**
Bariatric Surgery	**$25 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$100 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$100 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$100 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$10 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$100 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$10 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$6 Copayment**	**No limit**
Tier 2	**$15 Copayment**	**No limit**
Tier 3	**$30 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$18 Copayment**	**No limit**
Tier 2	**$45 Copayment**	**No limit**
Tier 3	**$90 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$15 Copayment**	**No limit**
Tier 2	**$38 Copayment**	**No limit**
Tier 3	**$75 Copayment**	**No limit**
Enteral Formulas	**5% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$10 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$10 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$10 Copayment after deductible**	
Orthodontics	**$10 Copayment after deductible**	
Vision Care		
Exams	**$10 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**5% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**5% Coinsurance after deductible**	

Section II.K – Silver 150-200% FPL Non-Standard Plan Benefit Description

Healthfirst Silver Leaf Premier CSR 150-200 Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$250**	
· **Family**	**$750**	
Out-of-Pocket Limit		
· **Individual**	**$2,000**	
· **Family**	**$4,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$15 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$35 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$35 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$35 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$75 Copayment after deductible**	**No limit**
Emergency Department	**$75 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$75 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$15 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$15 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$15 Copayment after deductible	No limit
Performed in a Specialist Office	$15 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$15 Copayment after deductible	No limit
Chiropractic Services	$35 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$15 Copayment after deductible	No limit
Performed in a Specialist Office	$35 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$35 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$15 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$15 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$15 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$15 Copayment after deductible	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	$15 Copayment after deductible	No limit
Performed in Specialist Office	$15 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$15 Copayment after deductible	No limit
Home Infusion Therapy	$15 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$15 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$35 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$35 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$250 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$75 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$75 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$15 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$35 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$35 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$15 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$15 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$25 Copayment after deductible**	**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 and Other	**$35 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$75 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$75 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$75 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$75 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$75 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$15 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$15 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$15 Copayment after deductible**	**No limit**
Diabetic Education	**$15 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**10% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**10% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**10% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$250 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$15 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**10% Coinsurance after deductible**	
Prosthetic Devices		
External	**10% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**10% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$250 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$75 Copayment after deductible**	**No limit**
Bariatric Surgery	**$75 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$250 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$250 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$250 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$15 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$250 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$15 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$9 Copayment**	**No limit**
Tier 2	**$20 Copayment**	**No limit**
Tier 3	**$40 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$27 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$23 Copayment**	**No limit**
Tier 2	**$50 Copayment**	**No limit**
Tier 3	**$100 Copayment**	**No limit**
Enteral Formulas	**10% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$15 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$15 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$15 Copayment after deductible**	
Orthodontics	**$15 Copayment after deductible**	
Vision Care		
Exams	**$15 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**10% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**10% Coinsurance after deductible**	

Section II.L – Silver 200-250% FPL Non-Standard Plan Benefit Description

Healthfirst Silver Leaf CSR 200-250 Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$1,200**	
· **Family**	**$2,400**	
Out-of-Pocket Limit		
· **Individual**	**$5,200**	
· **Family**	**$10,400**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$30 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$50 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$50 Copayment after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**$50 Copayment after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Chiropractic Services	$50 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	$30 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	$30 Copayment after deductible	

Setting		
Performed as Outpatient Hospital Services	$30 Copayment after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	$30 Copayment after deductible	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	$30 Copayment after deductible	No limit
Performed in Specialist Office	$30 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$30 Copayment after deductible	No limit
Home Infusion Therapy	$30 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$30 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$50 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$50 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**$1,500 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$30 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$50 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$50 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$30 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$30 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**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 and Other	**$50 Copayment after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**$100 Copayment after deductible**	**No limit**
Inpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Outpatient Hospital Surgery	**$100 Copayment after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**$100 Copayment after deductible**	**No limit**
Office Surgery	**Cost sharing determined by provider type, whether PCP or SPC**	**No limit**
Elective Termination of Pregnancy	**$100 Copayment after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**$30 Copayment after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**$30 Copayment after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**$30 Copayment after deductible**	**No limit**
Diabetic Education	**$30 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**25% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**25% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**25% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,500 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$30 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**25% Coinsurance after deductible**	
Prosthetic Devices		
External	**25% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**25% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,500 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**

Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,500 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**$1,500 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**$30 Copayment after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**$1,500 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**$30 Copayment after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**

Up to a 90-day supply for Maintenance Drugs		
Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**25% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**$30 Copayment after deductible**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$30 Copayment after deductible**	

Major Dental (Endodontics, Periodontics and Prosthodontics)	**$30 Copayment after deductible**	
Orthodontics	**$30 Copayment after deductible**	
Vision Care		
Exams	**$30 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**25% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**25% Coinsurance after deductible**	

Section II.M – Bronze Non-Standard Plan Benefit Description

Healthfirst Bronze Leaf Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$3,000**	
· **Family**	**$6,000**	
Out-of-Pocket Limit		
· **Individual**	**$6,350**	
· **Family**	**$12,700**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**50% Coinsurance after deductible**	**No limit**
Specialist Office Visits (or home visits)	**50% Coinsurance after deductible**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**50% Coinsurance after deductible**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**50% Coinsurance after deductible**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**50% Coinsurance after deductible**	**No limit**
Emergency Department	**50% Coinsurance after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**50% Coinsurance after deductible**	**No limit**
Anesthesia Services (all settings)	**50% Coinsurance after deductible**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Chiropractic Services	50% Coinsurance after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	50% Coinsurance after deductible	
Performed in a Freestanding Center or Specialist Office	50% Coinsurance after deductible	

Setting		
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	50% Coinsurance after deductible	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 after deductible	No limit
Performed in Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Home Infusion Therapy	50% Coinsurance after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	50% Coinsurance after deductible	No limit
Laboratory Procedures		
Performed in a PCP Office	50% Coinsurance after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	50% Coinsurance after deductible	No limit
Performed as Outpatient Hospital Services	50% Coinsurance after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit

Inpatient Hospital Services and Birthing Center	**50% Coinsurance after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**50% Coinsurance after deductible**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**50% Coinsurance after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**50% Coinsurance after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**50% Coinsurance after deductible**	**No limit**
Performed as Outpatient Hospital Services	**50% Coinsurance after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**50% Coinsurance after deductible**	**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 and Other	**50% Coinsurance after deductible**	**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		**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.**
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	**50% Coinsurance after deductible**	**No limit**
Inpatient Hospital Surgery	**50% Coinsurance after deductible**	**No limit**
Outpatient Hospital Surgery	**50% Coinsurance after deductible**	**No limit**
Surgery Performed at an Ambulatory Surgical Center	**50% Coinsurance after deductible**	**No limit**
Office Surgery	**50% Coinsurance after deductible**	**No limit**
Elective Termination of Pregnancy	**50% Coinsurance after deductible**	**1 Treatment per Year; Therapeutic termination of pregnancy unlimited**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
ABA Treatment for Autism Spectrum Disorder	**50% Coinsurance after deductible**	**680 Hours Per Plan Year**

Assistive Communication Devices for Autism Spectrum Disorder	**50% Coinsurance after deductible**	**Limited to dedicated devices**
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	**50% Coinsurance after deductible**	**No limit**
Diabetic Education	**50% Coinsurance after deductible**	**No limit**
Durable Medical Equipment and Braces	**50% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**50% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**50% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**50% Coinsurance after deductible**	**210 Days per Plan Year**
Outpatient	**50% Coinsurance after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**50% Coinsurance after deductible**	
Prosthetic Devices		
External	**50% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**50% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**50% Coinsurance after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**50% Coinsurance after deductible**	**No limit**

Bariatric Surgery	**50% Coinsurance after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**50% Coinsurance after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**50% Coinsurance after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**50% Coinsurance after deductible. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**50% Coinsurance after deductible**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**50% Coinsurance after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**50% Coinsurance after deductible**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**$10 Copayment**	**No limit**
Tier 2	**$35 Copayment**	**No limit**
Tier 3	**$70 Copayment**	**No limit**
Up to a 90-day supply for Maintenance Drugs		

Tier 1	**$30 Copayment**	**No limit**
Tier 2	**$105 Copayment**	**No limit**
Tier 3	**$210 Copayment**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**$25 Copayment**	**No limit**
Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**50% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**50% Coinsurance after deductible**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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**
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Dental Care		
Preventive Dental Care	**50% Coinsurance after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**50% Coinsurance after deductible**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**50% Coinsurance after deductible**	

Orthodontics	**50% Coinsurance after deductible**	
Vision Care		
Exams	**50% Coinsurance after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**50% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**50% Coinsurance after deductible**	

Section II.N – Native American/Alaska Native Non-Standard Plan Benefit Description

Healthfirst Native American/Alaskan Native Premier CSR Non-Standard Benefits		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
· **Individual**	**$0**	
· **Family**	**$0**	
Out-of-Pocket Limit		
· **Individual**	**$0**	
· **Family**	**$0**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**Covered in full**	**No limit**
Specialist Office Visits (or home visits)	**Covered in full**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**Covered in full**	**No limit**

Bone Density Testing*	**Covered in full**	**No limit**
Screening for Prostate Cancer	**Covered in full**	**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**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**Covered in full**	**No limit**
Emergency Department	**Covered in full**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**Covered in full**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**

Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Performed as Inpatient Hospital Services	**Covered in full**	**No limit**
Chemotherapy		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Chiropractic Services	**Covered in full**	**No limit**
Clinical Trials	**Covered in full**	
Diagnostic Testing		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**Covered in full**	
Performed in a Freestanding Center or Specialist Office Setting	**Covered in full**	
Performed as Outpatient	**Covered in full**	

Hospital Services		
Habilitation Services	**Covered in full**	**60 visits per condition, per lifetime combined therapies**
(Physical Therapy, Occupational Therapy or Speech Therapy)		
Home Health Care	**Covered in full**	**40 Visits per Plan Year**
Infertility Services	**Covered in full**	**• Member must be between ages of 21 and 44** **• Advanced infertility not covered**
Infusion Therapy		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Home Infusion Therapy	**Covered in full**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**
Inpatient Hospital Services and Birthing Center	**Covered in full**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**

Physician Midwife Services for Delivery	**Covered in full**	**No limit**
Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**Covered in full**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**Covered in full**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**Covered in full**	**No limit**
Performed as Outpatient Hospital Services	**Covered in full**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**Covered in full**	**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 and Other	**Covered in full**	**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		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.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	Covered in full	No limit
Inpatient Hospital Surgery	Covered in full	No limit
Outpatient Hospital Surgery	Covered in full	No limit
Surgery Performed at an Ambulatory Surgical Center	Covered in full	No limit
Office Surgery	Covered in full	No limit
Elective Termination of Pregnancy	Covered in full	1 Treatment per Year; Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	Covered in full	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	Covered in full	No limit

Diabetic Education	**Covered in full**	**No limit**
Durable Medical Equipment and Braces	**Covered in full**	**Coverage for standard equipment only.**
External Hearing Aids	**Covered in full**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**Covered in full**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**Covered in full**	**210 Days per Plan Year**
Outpatient	**Covered in full**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**Covered in full**	
Prosthetic Devices		
External	**Covered in full**	**One prosthetic device, per limb, per lifetime**
Internal	**Covered in full**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**Covered in full. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**Covered in full**	**No limit**
Bariatric Surgery	**Covered in full**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**Covered in full**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)	**Covered in full**	**60 Consecutive Days Per Condition, Per Lifetime**

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	**Covered in full. Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	**Covered in full**	**No limit**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	**Covered in full Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Outpatient Substance Use Services	**Covered in full**	**No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling**
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	
Retail Pharmacy		
30-day supply		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**
Tier 3	**Covered in full**	**No limit**
Up to a 90-day supply for Maintenance Drugs		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**
Tier 3	**Covered in full**	**No limit**
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	**Covered in full**	**No limit**
Tier 2	**Covered in full**	**No limit**

Tier 3	**Covered in full**	**No limit**
Enteral Formulas	**Covered in full**	**No limit**
Off Label Cancer Drugs	**Covered in full**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• 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 and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**Covered in full**	**One dental exam and cleaning per 6-month period** **Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**Covered in full**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**Covered in full**	
Orthodontics	**Covered in full**	
Pediatric Vision Care		
Exams	**Covered in full**	**One Exam Per 12-Month Period**
Lenses and Frames	**Covered in full**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**Covered in full**	

SECTION III – Underwriting Guidelines

Healthfirst PHSP, Inc.'s (Healthfirst) individual Direct Pay products are available for enrollment by eligible individuals and families. Coverage is intended for persons of majority age (and those younger than the majority age in the case of Direct Pay child-only plans) but younger than 65 years and not eligible for Medicare.

All Direct Pay products are made available in accordance with applicable state and federal laws and regulations, including New York's community rating and guaranteed issue laws. Enrollment into Healthfirst's Direct Pay products, both on- and off-Exchange, is limited to annual Open Enrollment periods and Special Enrollment periods.

A. ELIGIBILITY REQUIREMENTS:

- Applicants must live or reside within Healthfirst's service area, which, for the 2015 coverage year, includes New York, Richmond, Queens, Kings, Bronx, Nassau and Suffolk Counties.

- The following types of dependents are eligible to enroll in the policyholder's coverage: legal spouses; domestic partners; unmarried dependent children; natural children; legally adopted children; legal wards; step children; unmarried disabled/mentally retarded child; and children for whom the policyholder is the proposed adoptive parent without regard to financial dependence, residency with the policyholder, student status or employment.

- Foster Children and grandchildren are ineligible for dependent coverage.

- Individuals enrolled under group or another Direct Pay plan which would duplicate any benefits covered under Healthfirst's policy, are ineligible.

B. COVERAGE TERMINATION

Direct Pay coverage may be terminated under a variety of circumstances, as described in the subscriber contract. These include but are not limited to:

- Failure to pay outstanding premium amounts by the end of the grace period.
- The policyholder no longer lives or resides in Healthfirst's service area.
- Upon the policyholder's death. Surviving dependents will be terminated as of the last day of the month for which the premium has been paid.
- For spouses, on the date of divorce.
- For children, at the end of the month in which the child turns 26 years of age (unless an Age 29 Rider is selected).
- Upon the receipt of a written termination request which has been delivered at least 30 days prior to the request termination date.
- No longer meeting the eligibility requirements.
- The performance of an act that constitutes fraud or the intentional misrepresentation of material fact in writing on the policyholder's enrollment application.

EXHIBIT 11: GENERAL INFORMATION ABOUT THE RATE FILING

Company Name: Healthfirst PHSP, Inc.
NAIC Code: [redacted]
SERFF Tracking #: [redacted]
Market Segment: Individuals On Exchange

A. Insurer Information:

Healthfirst PHSP, Inc.	HMO - 44	Not-for-Profit	[redacted]
Company submitting the rate filing request	Company Type	Org. Type	Company NAIC Code

100 Church Street, 18th Floor, New York, NY 10007
Company mailing address

B. Contact Person:

[redacted]	[redacted]	[redacted]
Rate filing contact person name, title	Contact phone number	Contact Email address

C. Actuarial Contact (If different from above):

[redacted]	[redacted]	[redacted]
Actuary name, title	Actuary phone number	Actuary Email address

D. New Rate Information:

January 1, 2015 - December 31, 2015	1/1/2015	[redacted]
New rate applicability period	New rate effective date	SERFF Tracking Number

E. Market segment included in filing (e.g., Small Group (including Healthy NY Small Group), Individual - only one market segment per rate adjustment filing): Individual

F. Provide responses for the following questions:

	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (1). If yes, provide a brief description of the contract language changes included in this filing.	No
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing? If yes, mention these filings on Exhibit 16.	No
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (2).	Yes. Sent June 12, 2014.
4. Have all the required exhibits been submitted with this rate filing? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary and numerical summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of	Yes. SERFF tracking number: [redacted]

Notes:

(1) As mentioned in the checklist, this combined non-grandfathered product rate adjustment and form/rate filing can only include minor contract revisions, such as due to changes in the model language, changes to the catastrophic plan due to change in out of pocket maximum, changes to the standard plan designs. Substantial changes need to be submitted as a separate rate and form filing (e.g., a new plan design not replacing an existing plan design, contract language changes not just due to changes in the model language).

(2) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment filing is submitted to the Department of Financial Services.

healthfirst

June 13, 2014

[redacted]
Health Bureau
New York State Department of Financial Services
One State Street
New York, NY 10004

RE: Form Readability Certification
Healthfirst PHSP, Inc. - On- and Off-Exchange Individual HMO Plans
Submission Effective January 1, 2015
Rates and Forms Application Under New York Insurance Law Section 4308(c)

Dear [redacted]

As part of Healthfirst PHSP, Inc.'s (Healthfirst) premium rates and forms submission for plans with an effective date of January 1, 2015, and pursuant to the Review Standards for Individual Marketplace Checklist, dated April 15, 2014, we have included a policy and form Readability Certification.

Although the forms filed as part of this submission use Model Language the Flesch reading ease test score does not meet the minimum score of 45. The Readability Certification we have submitted indicates that this standard has not been met, while also noting the actual Flesch reading ease score of each policy/form we are submitting in this filing.

If you have any questions regarding this matter please feel free to contact [redacted] Thank you for your time and consideration. We look forward to continue working with you and New York State of Health.

Sincerely,

[redacted]

[redacted]
Senior Vice-President, General Counsel

New York Readability Certification

This is to certify that the forms listed below are in compliance with New York's Insurance Policy Readability Law.

A. Scoring Option *(select one)*

○ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____ .

◉ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for each policy form are indicated below.

B. Scope of Test *(select one)*

◉ 1. Test was applied to entire policy form(s).

○ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards of Certification (A checked block indicates the standard has been achieved.)

○ 1. The text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

◉ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables.)

◉ 3. Layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

◉ 4. The section titles are captioned in bold face or otherwise stand out significantly from the text.

◉ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

◉ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

◉ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

The undersigned officer of the insurer certifies that the forms in this filing meet the minimum reading ease score. Following are the individual Flesch Scores for each form submitted with this filing:

Form #	Words	Sentences	Syllables	Flesch Score
HF-STDIND-15	32892	1392	57038	35.8
HF-STDCO-15	32046	1367	55718	35.6
HF-STDCC-15	32862	1393	57040	35.7
HF-BSOB-15	2969	11	3222	24.9
HF-SSOB-15	2985	11	3291	24.9
HF-S100SOB-I5	2829	11	2639	24.9
HF-S150SOB-15	2986	11	3296	24.9

(Insert signature, name of officer, title of officer, and name of insurer)

[redacted]

(To list more forms, complete and submit the 'Additional s)' attached to the requirement for Readability cation. If submitting multiple sheets complete and them individually.)

Reset Form

Unified Rate Review v2.0.2

Company Legal Name:	**Healthfirst PHSP, Inc.**	State:	**NY**
HIOS Issuer ID:	**91237**	Market:	**Individual**
Effective Date of Rate Change(s):	**1/1/2015**		

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2013 to 12/31/2013

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$1	#DIV/0!	#DIV/0!
Incurred Claims in Experience Period	$1	#DIV/0!	#DIV/0!
Allowed Claims:	$1	#DIV/0!	#DIV/0!
Index Rate of Experience Period		$0.00	
Experience Period Member Months	0		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2015 to 12/31/2015 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				**Adj't. from Experience to Projection Period**		**Annualized Trend Factors**		**Projections, before credibility Adjustment**			**Credibility Manual**		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	0.00	$0.00	$0.00	1.000	1.000	1.000	1.000	0.00	$0.00	$0.00	100.19	$16,213.00	$135.36
Outpatient Hospital	Services	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	3702.91	266.09	82.11
Professional	Services	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	14519.13	126.67	153.26
Other Medical	Services	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	305.04	233.53	5.94
Capitation	Other	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	0.00	0.00	0.00
Prescription Drug	Prescriptions	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	21568.28	62.69	112.68
Total				$0.00							$0.00			$489.36

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$489.36	$257,560,267
Paid to Allowed Average Factor in Projection Period			0.724	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$354.13	$186,389,021
Projected Risk Adjustments PMPM			1.66	872,765
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$352.47	$185,516,257
Projected ACA reinsurance recoveries, net of rein prem, PMPM			16.45	8,657,162
Projected Incurred Claims			$336.03	$176,859,095
Administrative Expense Load	12.00%		47.34	24,916,255
Profit & Risk Load	2.00%		7.89	4,152,709
Taxes & Fees	0.82%		3.24	1,707,401
Single Risk Pool Gross Premium Avg. Rate, PMPM			$394.50	$207,635,461
Index Rate for Projection Period			$482.23	
% increase over Experience Period			#DIV/0!	
% Increase, annualized:			#DIV/0!	
Projected Member Months				526,325

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name:	**Healthfirst PHSP, Inc.**	State:	**NY**
HIOS Issuer ID:	**91237**	Market:	**Individual**
Effective Date of Rate Change(s):	**1/1/2015**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product																							Healthfirst HMO Indivic
Product ID:																							91237NY002
Metal:		Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum	Catastrophic	Bronze	Silver	Gold	Platinum	Bronze	Bronze	Silver	Silver	Gold	Gold	Platinum	Platinum
AV Metal Value		0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881	0.594	0.620	0.707	0.791	0.881	0.620	0.620	0.707	0.707	0.791	0.791	0.881	0.881
AV Pricing Value		0.707	0.714	0.829	0.837	0.970	0.980	1.149	1.161	0.438	0.707	0.829	0.970	1.149	0.707	0.714	0.829	0.837	0.970	0.980	1.149	1.161
Plan Type:		HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Plan Name		Dependent Age 26 & Dental, On-Exchange	Dependent Age 29 & Dental, On-Exchange	Dependent Age 26 & Dental, On-Exchange	Dependent Age 29 & Dental, On-Exchange	Dependent Age 26 & Dental, On-Exchange	Dependent Age 29 & Dental, On-Exchange	Dependent Age 26 & Dental, On-Exchange	Dependent Age 29 & Dental, On-Exchange	Dependent Age 26 & Dental, On-Exchange	Child-Only Bronze with Dental, On-Exchange	Child-Only Silver with Dental, On-Exchange	Child-Only Gold with Dental, On-Exchange	Platinum with Dental, On-Exchange	Dependent Age 26 & Dental, Off-Exchange	Dependent Age 29 & Dental, Off-Exchange	Dependent Age 26 & Dental, Off-Exchange	Dependent Age 29 & Dental, Off-Exchange	Dependent Age 26 & Dental, Off-Exchange	Dependent Age 29 & Dental, Off-Exchange	Dependent Age 26 & Dental, Off-Exchange	Dependent Age 29 & Dental, Off-Exchange
Plan ID (Standard Component ID):		91237NY0020001	91237NY0020002	91237NY0020005	91237NY0020006	91237NY0020009	91237NY0020010	91237NY0020013	91237NY0020014	91237NY0020017	91237NY0020019	91237NY0020021	91237NY0020023	91237NY0020025	91237NY0020027	91237NY0020028	91237NY0020031	91237NY0020032	91237NY0020035	91237NY0020036	91237NY0020039	91237NY0020040
Exchange Plan?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2																						-100.00%
Historical Rate Increase - Calendar Year - 1																						-100.00%
Historical Rate Increase - Calendar Year 0																						-100.00%
Effective Date of Proposed Rates		1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015
Rate Change % (over prior filing)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.88%	-9.88%	-9.82%	-9.82%	-9.70%	-9.70%	-9.68%	-9.68%
Cum'tive Rate Change % (over 12 mos prior)		-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-9.88%	-9.88%	-9.82%	-9.82%	-9.70%	-9.70%	-9.68%	-9.68%
Proj'd Per Rate Change % (over Exper. Period)		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %																						-9.81%

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	91237NY0020001	91237NY0020002	91237NY0020005	91237NY0020006	91237NY0020009	91237NY0020010	91237NY0020013	91237NY0020014	91237NY0020017	91237NY0020019	91237NY0020021	91237NY0020023	91237NY0020025	91237NY0020027	91237NY0020028	91237NY0020031	91237NY0020032	91237NY0020035	91237NY0020036	91237NY0020039	91237NY0020040
Inpatient	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.28	$0.28	$0.39	$0.40	$0.61	$0.61	$0.74	$0.75
Outpatient	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.01	$3.04	$3.56	$3.60	$4.26	$4.30	$5.06	$5.11
Professional	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$34.00	-$34.34	-$39.75	-$40.15	-$46.29	-$46.76	-$54.84	-$55.38
Prescription Drug	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.87	$5.93	$6.93	$7.00	$8.23	$8.31	$9.77	$9.87
Other	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$0.95	-$0.96	-$1.11	-$1.12	-$1.29	-$1.31	-$1.53	-$1.55
Capitation	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$2.55	-$2.57	-$2.95	-$2.98	-$3.38	-$3.41	-$4.00	-$4.04
Taxes & Fees	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.53	$7.60	$8.81	$8.89	$10.27	$10.37	$12.17	$12.29
Risk & Profit Charge	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$0.42	-$0.43	-$0.49	-$0.50	-$0.56	-$0.57	-$0.67	-$0.67
Total Rate Increase	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$21.24	-$21.46	-$24.61	-$24.86	-$28.16	-$28.44	-$33.30	-$33.63
Member Cost Share Increase	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$12.10	-$12.10	-$12.10	-$12.10	-$12.10	-$12.10	-$12.10	-$12.10

Average Current Rate PMPM	$394.57	$328.08	$331.36	$384.55	$388.40	$450.12	$454.62	$533.44	$538.77	$203.20	$328.08	$384.55	$450.12	$533.44	$349.32	$352.81	$409.16	$413.25	$478.28	$483.06	$566.74	$572.40
Projected Member Months	526,325	35,709	1,879	252,182	13,273	13,322	701	19,150	1,008	378	336	2,373	125	180	171	9	1,204	63	64	3	91	5

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	91237NY0020001	91237NY0020002	91237NY0020005	91237NY0020006	91237NY0020009	91237NY0020010	91237NY0020013	91237NY0020014	91237NY0020017	91237NY0020019	91237NY0020021	91237NY0020023	91237NY0020025	91237NY0020027	91237NY0020028	91237NY0020031	91237NY0020032	91237NY0020035	91237NY0020036	91237NY0020039	91237NY0020040
Average Rate PMPM	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Months	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHB Percent of TP, [see instructions]	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
state mandated benefits portion of TP that are other than EHB	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	#DIV/0!	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHB Percent of TAC, [see instructions]	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
state mandated benefits portion of TAC that are other than EHB	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	#DIV/0!	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Allowed Claims which are not the issuer's obligation:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Incurred claims, payable with issuer funds	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Incurred Claims PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Allowed Claims PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
EHB portion of Allowed Claims, PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

:tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	91237NY0020001	91237NY0020002	91237NY0020005	91237NY0020006	91237NY0020009	91237NY0020010	91237NY0020013	91237NY0020014	91237NY0020017	91237NY0020019	91237NY0020021	91237NY0020023	91237NY0020025	91237NY0020027	91237NY0020028	91237NY0020031	91237NY0020032	91237NY0020035	91237NY0020036	91237NY0020039	91237NY0020040
Plan Adjusted Index Rate	$394.49	$328.08	$331.36	$384.55	$388.40	$450.12	$454.62	$533.44	$538.77	$203.20	$328.08	$384.55	$450.12	$533.44	$328.08	$331.36	$384.55	$388.40	$450.12	$454.62	$533.44	$538.77
Member Months	526,325	35,709	1,879	252,182	13,273	13,322	701	19,150	1,008	378	336	2,373	125	180	171	9	1,204	63	64	3	91	5
Total Premium (TP)	$207,629,717	$11,715,293	$622,621	$96,976,936	$5,155,192	$5,996,510	$318,690	$10,215,358	$543,084	$76,811	$110,234	$912,540	$56,265	$96,019	$56,101	$2,982	$463,000	$24,469	$28,808	$1,364	$48,543	$2,694
EHB Percent of TP, [see instructions]	98.54%	99.68%	98.70%	99.69%	98.71%	99.71%	98.72%	99.73%	98.74%	99.50%	99.68%	99.69%	99.71%	99.73%	100.00%	99.01%	100.00%	99.01%	100.00%	99.01%	100.00%	99.01%
state mandated benefits portion of TP that are other than EHB	0.05%	0.00%	0.99%	0.00%	0.99%	0.00%	0.99%	0.00%	0.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.99%	0.00%	0.99%	0.00%	0.99%	0.00%	0.99%
Other benefits portion of TP	1.41%	0.32%	0.31%	0.31%	0.30%	0.29%	0.29%	0.27%	0.27%	0.50%	0.32%	0.31%	0.29%	0.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$257,561,736	$16,583,536	$881,530	$121,201,848	$6,443,979	$6,744,038	$358,458	$10,373,360	$551,519	$111,863	$156,041	$1,140,494	$63,279	$97,504	$79,414	$4,222	$578,658	$30,586	$32,399	$1,534	$49,294	$2,736
EHB Percent of TAC, [see instructions]	98.54%	99.68%	98.70%	99.69%	98.71%	99.71%	98.72%	99.73%	98.74%	99.50%	99.68%	99.69%	99.71%	99.73%	100.00%	99.01%	100.00%	99.01%	100.00%	99.01%	100.00%	99.01%
state mandated benefits portion of TAC that are other than EHB	0.05%	0.00%	0.99%	0.00%	0.99%	0.00%	0.99%	0.00%	0.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.99%	0.00%	0.99%	0.00%	0.99%	0.00%	0.99%
Other benefits portion of TAC	1.41%	0.32%	0.31%	0.31%	0.30%	0.29%	0.29%	0.27%	0.27%	0.50%	0.32%	0.31%	0.29%	0.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	$80,701,599	$6,611,501	$351,281	$38,650,113	$2,053,252	$1,639,232	$87,008	$1,676,646	$88,907	$48,158	$62,210	$363,693	$15,381	$15,760	$31,661	$1,683	$184,528	$9,746	$7,875	$372	$7,967	$441
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$32,158,558	$0	$0	$19,339,781	$1,028,658	$0	$0	$0	$0	$0	$0	$181,985	$0	$0	$0	$0	$92,334	$4,883	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	39.85%	0.00%	0.00%	50.04%	50.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	50.04%	0.00%	0.00%	0.00%	0.00%	50.04%	50.10%	0.00%	0.00%	0.00%	0.00%
Total Incurred claims, payable with issuer funds	$176,860,137	$9,972,035	$530,248	$82,551,735	$4,390,727	$5,104,806	$271,451	$8,696,715	$462,612	$63,706	$93,831	$776,801	$47,898	$81,745	$47,753	$2,540	$394,129	$20,840	$24,524	$1,162	$41,326	$2,295
Net Amt of Rein	$8,657,180	$472,211	$24,848	$4,078,481	$214,661	$261,066	$13,737	$458,589	$24,139	$4,732	$4,443	$38,378	$2,450	$4,310	$2,261	$119	$19,472	$1,019	$1,254	$59	$2,179	$120
Net Amt of Risk Adj	$872,767	$49,275	$2,593	$412,254	$21,698	$25,720	$1,353	$44,171	$2,325	$321	$464	$3,879	$241	$415	$236	$12	$1,968	$103	$124	$6	$210	$12