

**HEALTHFIRST PHSP, INC.**

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

**Off-Exchange Individual HMO Rates and Forms Submission**

**Effective January 1, 2015**

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# **SECTION I – OFF-Exchange Individual HMO Plan Rates**

**Section I.A – Rate Pages: Standard Plans**

**HEALTHFIRST PHSP, INC.  
OFF-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 HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D	Healthfirst HMO E
<b>METAL LEVEL</b>	Platinum	Gold	Silver	Bronze	Catastrophic
<i>Single</i>	\$537.48	\$453.53	\$387.46	\$330.56	\$204.74
<i>Single + spouse</i>	\$1,074.95	\$907.05	\$774.92	\$661.12	\$409.48
<i>Single + child(ren)</i>	\$913.71	\$771.00	\$658.68	\$561.95	\$348.06
<i>Single + spouse + child(ren)</i>	\$1,531.81	\$1,292.55	\$1,104.27	\$942.10	\$583.51

*Form Numbers of policies to which these rates apply:*

Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
HF-STDIND-15-OFF	HF-STDIND-15-OFF	HF-STDIND-15-OFF	HF-STDIND-15-OFF
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15

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

PLAN NAME	Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
<b>METAL LEVEL</b>	Platinum	Gold	Silver	Bronze
<i>Single</i>	\$5.37	\$4.53	\$3.88	\$3.31
<i>Single + spouse</i>	\$10.75	\$9.08	\$7.75	\$6.61
<i>Single + child(ren)</i>	\$9.14	\$7.71	\$6.59	\$5.62
<i>Single + spouse + child(ren)</i>	\$15.32	\$12.93	\$11.04	\$9.42

*Form Numbers of policies to which these rates apply:*

Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
HF-STDIND-15-OFF	HF-STDIND-15-OFF	HF-STDIND-15-OFF	HF-STDIND-15-OFF
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-A29R-15	HF-A29R-15	HF-A29R-15	HF-A29R-15

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

*Child-only*

PLAN NAME	Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
<b>METAL LEVEL</b>	Platinum	Gold	Silver	Bronze
<i>One Child</i>	\$221.44	\$186.85	\$159.63	\$136.19
<i>Two Children</i>	\$442.88	\$373.70	\$319.26	\$272.38
<i>Three or More Children</i>	\$664.32	\$560.55	\$478.89	\$408.57

*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

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

**HEALTHFIRST PHSP, INC.  
OFF-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 HMO A VAD	Healthfirst HMO B VAD	Healthfirst HMO C VAD	Healthfirst HMO D VAD
<b>METAL LEVEL</b>	Platinum	Gold	Silver	Bronze
<i>Single</i>	\$555.39	\$468.64	\$400.37	\$341.58
<i>Single + spouse</i>	\$1,110.78	\$937.28	\$800.75	\$683.15
<i>Single + child(ren)</i>	\$944.16	\$796.69	\$680.64	\$580.68
<i>Single + spouse + child(ren)</i>	\$1,582.86	\$1,335.63	\$1,141.07	\$973.49

*Form Numbers of policies to which these rates apply:*

Healthfirst HMO A VAD	Healthfirst HMO B VAD	Healthfirst HMO C VAD	Healthfirst HMO D VAD
HF-STDIND-15	HF-STDIND-15	HF-STDIND-15	HF-STDIND-15
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15

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

PLAN NAME	Healthfirst HMO A VAD	Healthfirst HMO B VAD	Healthfirst HMO C VAD	Healthfirst HMO D VAD
<b>METAL LEVEL</b>	Platinum	Gold	Silver	Bronze
<i>Single</i>	\$5.55	\$4.69	\$4.01	\$3.41
<i>Single + spouse</i>	\$11.10	\$9.38	\$8.01	\$6.83
<i>Single + child(ren)</i>	\$9.44	\$7.97	\$6.80	\$5.81
<i>Single + spouse + child(ren)</i>	\$15.82	\$13.36	\$11.41	\$9.74

*Form Numbers of policies to which these rates apply:*

Healthfirst HMO A	Healthfirst HMO B	Healthfirst HMO C	Healthfirst HMO D
HF-STDIND-15-OFF	HF-STDIND-15-OFF	HF-STDIND-15-OFF	HF-STDIND-15-OFF
HF-PSOB-15	HF-GSOB-15	HF-SSOB-15	HF-BSOB-15
HF-A29R-15	HF-A29R-15	HF-A29R-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 off-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 off-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 HMO B" 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 I.F – Broker/Agent Commissions & Fees**

Brokers/agents who sell the products and plans listed herein will not be compensated by Healthfirst for such sale. These products and plans thus do not include any consideration related to broker/agent commissions and/or fees.

## **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 – HMO A Standard Plan Benefit Description**

<b>Healthfirst HMO A (&amp; HMO A Child-Only) Standard Benefits</b>		
<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Deductible</b>		
Individual	\$0	
Family	\$0	
<b>Out-of-Pocket Limit</b>		
Individual	\$2,000	
Family	\$4,000	
<b>OFFICE VISITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Primary Care Office Visits (or home visits)	\$15 Copayment	No limit
Specialist Office Visits (or home visits)	\$35 Copayment	No limit
<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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	\$15 Copayment	No limit

<b>Bone Density Testing*</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Screening for Prostate Cancer</b>	<b>\$15 Copayment</b>	<b>Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.</b>
<b>Family Planning Services for Women</b>	<b>Covered in full</b>	<b>No limit</b>
<b>All other preventive services required by USPSTF and HRSA.</b>	<b>Covered in full</b>	<b>No limit</b>
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Pre-Hospital Emergency Medical Services (Ambulance Services)</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Emergency Department</b>	<b>\$100 Copayment</b> <b>Copayment / Coinsurance waived if Hospital admission</b>	<b>No limit</b>
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Advanced Imaging Services</b>		
<b>Performed in a Freestanding Radiology Facility or Office Setting</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Allergy Testing and Treatment</b>		
<b>Performed in a PCP Office</b>	<b>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &amp; Diagnostic Procedures)</b>	<b>No limit</b>
<b>Performed in a Specialist Office</b>		
<b>Ambulatory Surgical Center Facility Fee</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Anesthesia Services (all settings)</b>	<b>Covered in full</b>	<b>No limit</b>

<b>Cardiac and Pulmonary Rehabilitation</b>		
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
<b>Chemotherapy</b>		
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)	
<b>Diagnostic Testing</b>		
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
<b>Dialysis</b>		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	

<b>Setting</b>		
<b>Performed as Outpatient Hospital Services</b>	<b>\$15 Copayment</b>	
<b>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>	<b>\$25 Copayment</b>	<b>60 visits per condition, per lifetime combined therapies</b>
<b>Home Health Care</b>	<b>\$15 Copayment</b>	<b>40 Visits per Plan Year</b>
<b>Infertility Services</b>	<b>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</b>	<ul style="list-style-type: none"> <li>• <b>Member must be between ages of 21 and 44</b></li> <li>• <b>Advanced infertility not covered</b></li> </ul>
<b>Infusion Therapy</b>		
<b>Performed in a PCP Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed in Specialist Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Home Infusion Therapy</b>	<b>\$15 Copayment</b>	<b>Home Infusion counts towards Home Health Care Visit Limits</b>
<b>Inpatient Medical Visits</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Laboratory Procedures</b>		
<b>Performed in a PCP Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed in a Freestanding Laboratory Facility or Specialist Office</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Maternity and Newborn Care</b>		
<b>Prenatal Care</b>	<b>Covered in full</b>	<b>No limit</b>

<b>Inpatient Hospital Services and Birthing Center</b>	<b>\$500 Copayment per admission</b>	<b>No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</b>
<b>Physician Midwife Services for Delivery</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Breast Pump</b>	<b>Covered in full</b>	<b>Covered for duration of breast feeding</b>
<b>Postnatal Care</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery Facility Charge</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Diagnostic Radiology Services</b>		
<b>Performed in a PCP Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Therapeutic Radiology Services</b>		
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>	<b>\$25 Copayment</b>	<b>60 visits per condition, per lifetime combined therapies  Speech and Physical Therapy are only Covered following a Hospital stay or surgery.</b>

<b>Second Opinions on the Diagnosis of Cancer, Surgery and Other</b>	<b>\$35 Copayment</b>	<b>One second surgical opinion on the need for surgery</b>  <b>For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer</b>
<b>Surgical Services</b>		<b>No limit</b>  <b>Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational.</b>  <b>Oral Surgery due to injury is limited to sound and natural teeth only.</b>
<b>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Inpatient Hospital Surgery</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Surgery Performed at an Ambulatory Surgical Center</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Office Surgery</b>	<b>Cost sharing determined by provider type, whether PCP or SPC</b>	<b>No limit</b>
<b>Elective Termination of Pregnancy</b>	<b>\$100 Copayment</b>	<b>1 Treatment per Year; Therapeutic termination of pregnancy unlimited</b>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>ABA Treatment for Autism Spectrum Disorder</b>	<b>\$15 Copayment</b>	<b>680 Hours Per Plan Year</b>

<b>Assistive Communication Devices for Autism Spectrum Disorder</b>	<b>\$15 Copayment</b>	<b>Limited to dedicated devices</b>
<b>Diabetic Equipment, Supplies and Self-Management Education</b>		
<b>Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Diabetic Education</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Durable Medical Equipment and Braces</b>	<b>10% Coinsurance</b>	<b>Coverage for standard equipment only.</b>
<b>External Hearing Aids</b>	<b>10% Coinsurance</b>	<b>Single Purchase Once Every 3 Years</b>
<b>Cochlear Implants</b>	<b>10% Coinsurance</b>	<b>One Per Ear Per Time Covered</b>
<b>Hospice Care</b>		
<b>Inpatient</b>	<b>\$500 Copayment per admission</b>	<b>210 Days per Plan Year</b>
<b>Outpatient</b>	<b>\$15 Copayment</b>	<b>5 Visits for Family Bereavement Counseling</b>
<b>Medical Supplies</b>	<b>10% Coinsurance</b>	
<b>Prosthetic Devices</b>		
<b>External</b>	<b>10% Coinsurance</b>	<b>One prosthetic device, per limb, per lifetime</b>
<b>Internal</b>	<b>\$0 copay</b>	<b>No limit</b>
<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)</b>	<b>\$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions.</b>	<b>No limit</b>
<b>Observation Stay</b>	<b>\$100 Copayment</b>	<b>No limit</b>

<b>Bariatric Surgery</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)</b>	<b>\$500 Copayment per admission</b>	<b>200 Days Per Plan Year</b>
<b>Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)</b>	<b>\$500 Copayment per admission</b>	<b>60 Consecutive Days Per Condition, Per Lifetime</b>
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Inpatient Mental Health Care (for a continuous confinement when in a Hospital)</b>	<b>\$500 Copayment per admission</b>	<b>No limit</b>
<b>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Inpatient Substance Use Services (for a continuous confinement when in a Hospital)</b>	<b>\$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions</b>	<b>No limit</b>
<b>Outpatient Substance Use Services</b>	<b>\$15 Copayment</b>	<b>No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling</b>
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Retail Pharmacy</b>		
<b>30-day supply</b>		
<b>Tier 1</b>	<b>\$10 Copayment</b>	<b>No limit</b>
<b>Tier 2</b>	<b>\$30 Copayment</b>	<b>No limit</b>
<b>Tier 3</b>	<b>\$60 Copayment</b>	<b>No limit</b>
<b>Up to a 90-day supply for Maintenance Drugs</b>		

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 Copayment	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	<ul style="list-style-type: none"> <li>• Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</li> <li>• Partial reimbursement for facility fees every 6 months if member attains at least 50 visits</li> </ul>
<b>PEDIATRIC DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Pediatric Dental Care		
Preventive Dental Care	\$15 Copayment	<p>One dental exam and cleaning per 6-month period</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals</p>
Routine Dental Care	\$15 Copayment	
Major Dental (Endodontics, Periodontics and	\$15 Copayment	

<b>Prosthodontics)</b>		
<b>Orthodontics</b>	<b>\$15 Copayment</b>	
<b>Pediatric Vision Care</b>		
<b>Exams</b>	<b>\$15 Copayment</b>	<b>One Exam Per 12-Month Period</b>
<b>Lenses and Frames</b>	<b>10% Coinsurance</b>	<b>One Prescribed Lenses &amp; Frames in a 12-Month Period</b>
<b>Contact Lenses</b>	<b>10% Coinsurance</b>	

**Section II.B – HMO B Standard Plan Benefit Description**

<b>Healthfirst HMO B (&amp; HMO B Child-Only) Standard Benefits</b>		
<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Deductible</b>		
Individual	\$600	
Family	\$1,200	
<b>Out-of-Pocket Limit</b>		
Individual	\$4,000	
Family	\$8,000	
<b>OFFICE VISITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Primary Care Office Visits (or home visits)	\$25 Copayment	No limit
Specialist Office Visits (or home visits)	\$40 Copayment	No limit
<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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	\$25 Copayment after deductible	No limit

<b>Bone Density Testing*</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Screening for Prostate Cancer</b>	<b>\$25 Copayment after deductible</b>	<b>Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.</b>
<b>Family Planning Services for Women</b>	<b>Covered in full</b>	<b>No limit</b>
<b>All other preventive services required by USPSTF and HRSA.</b>	<b>Covered in full</b>	<b>No limit</b>
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Pre-Hospital Emergency Medical Services (Ambulance Services)</b>	<b>\$150 Copayment after deductible</b>	<b>No limit</b>
<b>Emergency Department</b>	<b>\$150 Copayment after deductible</b>	<b>No limit</b>
	<b>Copayment / Coinsurance waived if Hospital admission</b>	<b>No limit</b>
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Advanced Imaging Services</b>		
<b>Performed in a Freestanding Radiology Facility or Office Setting</b>	<b>\$40 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$40 Copayment after deductible</b>	<b>No limit</b>
<b>Allergy Testing and Treatment</b>		
<b>Performed in a PCP Office</b>	<b>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &amp; Diagnostic Procedures)</b>	<b>No limit</b>
<b>Performed in a Specialist Office</b>		
<b>Ambulatory Surgical Center Facility Fee</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Anesthesia Services (all settings)</b>	<b>Covered in full</b>	<b>No limit</b>

<b>Cardiac and Pulmonary Rehabilitation</b>		
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
<b>Chemotherapy</b>		
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)	
<b>Diagnostic Testing</b>		
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
<b>Dialysis</b>		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	

<b>Setting</b>		
<b>Performed as Outpatient Hospital Services</b>	<b>\$25 Copayment after deductible</b>	
<b>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>	<b>\$30 Copayment after deductible</b>	<b>60 visits per condition, per lifetime combined therapies</b>
<b>Home Health Care</b>	<b>\$25 Copayment after deductible</b>	<b>40 Visits per Plan Year</b>
<b>Infertility Services</b>	<b>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</b>	<ul style="list-style-type: none"> <li>• <b>Member must be between ages of 21 and 44</b></li> <li>• <b>Advanced infertility not covered</b></li> </ul>
<b>Infusion Therapy</b>		
<b>Performed in a PCP Office</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Performed in Specialist Office</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Home Infusion Therapy</b>	<b>\$25 Copayment after deductible</b>	<b>Home Infusion counts towards Home Health Care Visit Limits</b>
<b>Inpatient Medical Visits</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Laboratory Procedures</b>		
<b>Performed in a PCP Office</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Performed in a Freestanding Laboratory Facility or Specialist Office</b>	<b>\$40 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$40 Copayment after deductible</b>	<b>No limit</b>
<b>Maternity and Newborn Care</b>		
<b>Prenatal Care</b>	<b>Covered in full</b>	<b>No limit</b>

<b>Inpatient Hospital Services and Birthing Center</b>	<b>\$1,000 Copayment per admission after deductible</b>	<b>No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</b>
<b>Physician Midwife Services for Delivery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Breast Pump</b>	<b>Covered in full</b>	<b>Covered for duration of breast feeding</b>
<b>Postnatal Care</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery Facility Charge</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Diagnostic Radiology Services</b>		
<b>Performed in a PCP Office</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$40 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$40 Copayment after deductible</b>	<b>No limit</b>
<b>Therapeutic Radiology Services</b>		
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>	<b>\$30 Copayment after deductible</b>	<b>60 visits per condition, per lifetime combined therapies</b>  <b>Speech and Physical Therapy are only Covered following a Hospital stay or surgery.</b>

<b>Second Opinions on the Diagnosis of Cancer, Surgery and Other</b>	<b>\$40 Copayment after deductible</b>	<b>One second surgical opinion on the need for surgery</b>  <b>For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer</b>
<b>Surgical Services</b>		<b>No limit</b>  <b>Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational.</b>  <b>Oral Surgery due to injury is limited to sound and natural teeth only.</b>
<b>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Inpatient Hospital Surgery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Surgery Performed at an Ambulatory Surgical Center</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Office Surgery</b>	<b>Cost sharing determined by provider type, whether PCP or SPC</b>	<b>No limit</b>
<b>Elective Termination of Pregnancy</b>	<b>\$100 Copayment</b>	<b>1 Treatment per Year; Therapeutic termination of pregnancy unlimited</b>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>ABA Treatment for Autism Spectrum Disorder</b>	<b>\$25 Copayment after deductible</b>	<b>680 Hours Per Plan Year</b>

<b>Assistive Communication Devices for Autism Spectrum Disorder</b>	<b>\$25 Copayment after deductible</b>	<b>Limited to dedicated devices</b>
<b>Diabetic Equipment, Supplies and Self-Management Education</b>		
<b>Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Diabetic Education</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Durable Medical Equipment and Braces</b>	<b>20% Coinsurance after deductible</b>	<b>Coverage for standard equipment only.</b>
<b>External Hearing Aids</b>	<b>20% Coinsurance after deductible</b>	<b>Single Purchase Once Every 3 Years</b>
<b>Cochlear Implants</b>	<b>20% Coinsurance after deductible</b>	<b>One Per Ear Per Time Covered</b>
<b>Hospice Care</b>		
<b>Inpatient</b>	<b>\$1,000 Copayment per admission after deductible</b>	<b>210 Days per Plan Year</b>
<b>Outpatient</b>	<b>\$25 Copayment after deductible</b>	<b>5 Visits for Family Bereavement Counseling</b>
<b>Medical Supplies</b>	<b>20% Coinsurance after deductible</b>	
<b>Prosthetic Devices</b>		
<b>External</b>	<b>20% Coinsurance after deductible</b>	<b>One prosthetic device, per limb, per lifetime</b>
<b>Internal</b>	<b>\$0 copay after deductible</b>	<b>No limit</b>
<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)</b>	<b>\$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.</b>	<b>No limit</b>

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 (Physical, Speech and Occupational therapy)	\$1,000 Copayment per admission after deductible	60 Consecutive Days Per Condition, Per Lifetime
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Retail Pharmacy		
30-day supply		
Tier 1	\$10 Copayment	No limit
Tier 2	\$35 Copayment	No limit
Tier 3	\$70 Copayment	No limit

<b>Up to a 90-day supply for Maintenance Drugs</b>		
<b>Tier 1</b>	<b>\$30 Copayment</b>	<b>No limit</b>
<b>Tier 2</b>	<b>\$105 Copayment</b>	<b>No limit</b>
<b>Tier 3</b>	<b>\$210 Copayment</b>	<b>No limit</b>
<b>Mail Order Pharmacy</b>		
<b>Up to a 90-day supply</b>		
<b>Tier 1</b>	<b>\$25 Copayment</b>	<b>No limit</b>
<b>Tier 2</b>	<b>\$88 Copayment</b>	<b>No limit</b>
<b>Tier 3</b>	<b>\$175 Copayment</b>	<b>No limit</b>
<b>Enteral Formulas</b>	<b>\$10 Copayment</b>	<b>No limit</b>
<b>Off Label Cancer Drugs</b>	<b>Use appropriate prescription drug tier cost-sharing</b>	<b>30 day supply per month</b>
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Gym Reimbursement</b>	<b>Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</b>	<ul style="list-style-type: none"> <li>• <b>Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</b></li> <li>• <b>Partial reimbursement for facility fees every 6 months if member attains at least 50 visits</b></li> </ul>
<b>PEDIATRIC DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Pediatric Dental Care</b>		
<b>Preventive Dental Care</b>	<b>\$25 Copayment after deductible</b>	<b>One dental exam and cleaning per 6-month period</b>  <b>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals</b>
<b>Routine Dental Care</b>	<b>\$25 Copayment after deductible</b>	

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

**Section II.C – HMO C Standard Plan Benefit Description**

<b>Healthfirst HMO C (&amp; HMO C Child-Only) Standard Benefits</b>		
<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Deductible</b>		
• Individual	\$2,000	
• Family	\$4,000	
<b>Out-of-Pocket Limit</b>		
• Individual	\$5,500	
• Family	\$11,000	
<b>OFFICE VISITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Primary Care Office Visits (or home visits)	\$30 Copayment	No limit
Specialist Office Visits (or home visits)	\$50 Copayment	No limit
<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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	\$30 Copayment after deductible	No limit

Bone Density Testing*	Covered in full	No limit
Screening for Prostate Cancer	\$30 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
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Advanced Imaging Services</b>		
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
<b>Allergy Testing and Treatment</b>		
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

<b>Cardiac and Pulmonary Rehabilitation</b>		
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
<b>Chemotherapy</b>		
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)	
<b>Diagnostic Testing</b>		
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
<b>Dialysis</b>		<b>Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year</b>
Performed in a PCP Office	\$30 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office	\$30 Copayment after deductible	

<b>Setting</b>		
<b>Performed as Outpatient Hospital Services</b>	<b>\$30 Copayment after deductible</b>	
<b>Habilitation Services</b>	<b>\$30 Copayment after deductible</b>	<b>60 visits per condition, per lifetime combined therapies</b>
<b>(Physical Therapy, Occupational Therapy or Speech Therapy)</b>		
<b>Home Health Care</b>	<b>\$30 Copayment after deductible</b>	<b>40 Visits per Plan Year</b>
<b>Infertility Services</b>	<b>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</b>	<ul style="list-style-type: none"> <li>• Member must be between ages of 21 and 44</li> <li>• Advanced infertility not covered</li> </ul>
<b>Infusion Therapy</b>		
<b>Performed in a PCP Office</b>	<b>\$30 Copayment after deductible</b>	<b>No limit</b>
<b>Performed in Specialist Office</b>	<b>\$30 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$30 Copayment after deductible</b>	<b>No limit</b>
<b>Home Infusion Therapy</b>	<b>\$30 Copayment after deductible</b>	<b>Home Infusion counts towards Home Health Care Visit Limits</b>
<b>Inpatient Medical Visits</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Laboratory Procedures</b>		
<b>Performed in a PCP Office</b>	<b>\$30 Copayment after deductible</b>	<b>No limit</b>
<b>Performed in a Freestanding Laboratory Facility or Specialist Office</b>	<b>\$50 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$50 Copayment after deductible</b>	<b>No limit</b>
<b>Maternity and Newborn Care</b>		
<b>Prenatal Care</b>	<b>Covered in full</b>	<b>No limit</b>

<b>Inpatient Hospital Services and Birthing Center</b>	<b>\$1,500 Copayment per admission after deductible</b>	<b>No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</b>
<b>Physician Midwife Services for Delivery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Breast Pump</b>	<b>Covered in full</b>	<b>Covered for duration of breast feeding</b>
<b>Postnatal Care</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery Facility Charge</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Diagnostic Radiology Services</b>		
<b>Performed in a PCP Office</b>	<b>\$30 Copayment after deductible</b>	<b>No limit</b>
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$50 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$50 Copayment after deductible</b>	<b>No limit</b>
<b>Therapeutic Radiology Services</b>		
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$30 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$30 Copayment after deductible</b>	<b>No limit</b>
<b>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>	<b>\$30 Copayment after deductible</b>	<b>60 visits per condition, per lifetime combined therapies</b>  <b>Speech and Physical Therapy are only Covered following a Hospital stay or surgery.</b>

<b>Second Opinions on the Diagnosis of Cancer, Surgery and Other</b>	<b>\$50 Copayment after deductible</b>	<b>One second surgical opinion on the need for surgery</b>  <b>For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer</b>
<b>Surgical Services</b>		<b>No limit</b>  <b>Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational.</b>  <b>Oral Surgery due to injury is limited to sound and natural teeth only.</b>
<b>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Inpatient Hospital Surgery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Surgery Performed at an Ambulatory Surgical Center</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Office Surgery</b>	<b>Cost sharing determined by provider type, whether PCP or SPC</b>	<b>No limit</b>
<b>Elective Termination of Pregnancy</b>	<b>\$100 Copayment</b>	<b>1 Treatment per Year; Therapeutic termination of pregnancy unlimited</b>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>ABA Treatment for Autism Spectrum Disorder</b>	<b>\$30 Copayment after deductible</b>	<b>680 Hours Per Plan Year</b>

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	\$0 copay 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
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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	\$10 Copayment	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	<ul style="list-style-type: none"> <li>• Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</li> <li>• Partial reimbursement for facility fees every 6 months if member attains at least 50 visits</li> </ul>
<b>PEDIATRIC DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Pediatric Dental Care		
Preventive Dental Care	\$30 Copayment after deductible	<p>One dental exam and cleaning per 6-month period</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals</p>
Routine Dental Care	\$30 Copayment after deductible	

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

## Section II.D – HMO D Standard Plan Benefit Description

Healthfirst HMO D (& HMO D Child-Only)		
COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Limits
<b>Deductible</b>		
· Individual	\$3,000	
· Family	\$6,000	
<b>Out-of-Pocket Limit</b>		
· Individual	\$6,350	
· Family	\$12,700	
<b>OFFICE VISITS</b>	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
<b>PREVENTIVE CARE</b>	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
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Advanced Imaging Services</b>		
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
<b>Allergy Testing and Treatment</b>		
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
<b>Cardiac and Pulmonary</b>		

<b>Rehabilitation</b>		
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
<b>Chemotherapy</b>		
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)	
<b>Diagnostic Testing</b>		
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
<b>Dialysis</b>		<b>Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year</b>
Performed in a PCP Office	50% Coinsurance after deductible	
Performed in a Freestanding Center or Specialist Office Setting	50% Coinsurance after deductible	

Performed as Outpatient Hospital Services	50% Coinsurance after deductible	
Habilitation Services	50% Coinsurance after deductible	60 visits per condition, per lifetime combined therapies
(Physical Therapy, Occupational Therapy or Speech Therapy)		
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)	<ul style="list-style-type: none"> <li>• Member must be between ages of 21 and 44</li> <li>• Advanced infertility not covered</li> </ul>
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
<b>Diagnostic Radiology Services</b>		
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

<b>Surgical Services</b>		<b>No limit</b>  <b>Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational.</b>  <b>Oral Surgery due to injury is limited to sound and natural teeth only.</b>
<b>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Inpatient Hospital Surgery</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Surgery Performed at an Ambulatory Surgical Center</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Office Surgery</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Elective Termination of Pregnancy</b>	<b>50% Coinsurance after deductible</b>	<b>1 Treatment per Year; Therapeutic termination of pregnancy unlimited</b>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>ABA Treatment for Autism Spectrum Disorder</b>	<b>50% Coinsurance after deductible</b>	<b>680 Hours Per Plan Year</b>
<b>Assistive Communication Devices for Autism Spectrum Disorder</b>	<b>50% Coinsurance after deductible</b>	<b>Limited to dedicated devices</b>
<b>Diabetic Equipment, Supplies and Self-Management Education</b>		
<b>Diabetic Equipment, Supplies and Insulin (30-day; up to a</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>

90-day supply)		
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
<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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	50% Coinsurance after deductible	60 Consecutive Days Per Condition, Per Lifetime

Occupational therapy)		
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Inpatient Mental Health Care (for a continuous confinement when in a Hospital)</b>	<b>50% Coinsurance after deductible. Preauthorization is Not Required for Emergency Admissions.</b>	<b>No limit</b>
<b>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Inpatient Substance Use Services (for a continuous confinement when in a Hospital)</b>	<b>50% Coinsurance after deductible Preauthorization is Not Required for Emergency Admissions.</b>	<b>No limit</b>
<b>Outpatient Substance Use Services</b>	<b>50% Coinsurance after deductible</b>	<b>No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling</b>
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Retail Pharmacy</b>		
<b>30-day supply</b>		
<b>Tier 1</b>	<b>\$10 Copayment</b>	<b>No limit</b>
<b>Tier 2</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Tier 3</b>	<b>\$70 Copayment</b>	<b>No limit</b>
<b>Up to a 90-day supply for Maintenance Drugs</b>		
<b>Tier 1</b>	<b>\$30 Copayment</b>	<b>No limit</b>
<b>Tier 2</b>	<b>\$105 Copayment</b>	<b>No limit</b>
<b>Tier 3</b>	<b>\$210 Copayment</b>	<b>No limit</b>
<b>Mail Order Pharmacy</b>		
<b>Up to a 90-day supply</b>		

Tier 1	\$25 Copayment	No limit
Tier 2	\$88 Copayment	No limit
Tier 3	\$175 Copayment	No limit
Enteral Formulas	\$10 Copayment	No limit
Off Label Cancer Drugs	50% Coinsurance after deductible	30 day supply per month
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	<ul style="list-style-type: none"> <li>• Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</li> <li>• Partial reimbursement for facility fees every 6 months if member attains at least 50 visits</li> </ul>
<b>PEDIATRIC DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Pediatric Dental Care		
Preventive Dental Care	50% Coinsurance after deductible	<p>One dental exam and cleaning per 6-month period</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals</p>
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	
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## Section II.E – Catastrophic Standard Plan Benefit Description

Healthfirst HMO E		
COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Limits
<b>Deductible</b>		
• Individual	\$6,600	
• Family	\$13,200	
<b>Out-of-Pocket Limit</b>		
• Individual	\$6,600	
• Family	\$13,200	
<b>OFFICE VISITS</b>	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
<b>PREVENTIVE CARE</b>	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
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Advanced Imaging Services</b>		
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
<b>Allergy Testing and Treatment</b>		
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

<b>Cardiac and Pulmonary Rehabilitation</b>		
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
<b>Chemotherapy</b>		
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	
<b>Diagnostic Testing</b>		
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
<b>Dialysis</b>		<b>Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year</b>
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	

<b>Hospital Services</b>		
<b>Habilitation Services</b>	<b>Covered in full after deductible</b>	<b>60 visits per condition, per lifetime combined therapies</b>
<b>(Physical Therapy, Occupational Therapy or Speech Therapy)</b>		
<b>Home Health Care</b>	<b>Covered in full after deductible</b>	<b>40 Visits per Plan Year</b>
<b>Infertility Services</b>	<b>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</b>	<ul style="list-style-type: none"> <li>• Member must be between ages of 21 and 44</li> <li>• Advanced infertility not covered</li> </ul>
<b>Infusion Therapy</b>		
<b>Performed in a PCP Office</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Performed in Specialist Office</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Home Infusion Therapy</b>	<b>Covered in full after deductible</b>	<b>Home Infusion counts towards Home Health Care Visit Limits</b>
<b>Inpatient Medical Visits</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Laboratory Procedures</b>		
<b>Performed in a PCP Office</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Performed in a Freestanding Laboratory Facility or Specialist Office</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Maternity and Newborn Care</b>		
<b>Prenatal Care</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Inpatient Hospital Services and Birthing Center</b>	<b>Covered in full after deductible</b>	<b>No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</b>

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
<b>Diagnostic Radiology Services</b>		
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

<b>Surgical Services</b>		<b>No limit</b>  <b>Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational.</b>  <b>Oral Surgery due to injury is limited to sound and natural teeth only.</b>
<b>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Inpatient Hospital Surgery</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Surgery Performed at an Ambulatory Surgical Center</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Office Surgery</b>	<b>Covered in full after deductible</b>	<b>No limit</b>
<b>Elective Termination of Pregnancy</b>	<b>Covered in full after deductible</b>	<b>1 Treatment per Year; Therapeutic termination of pregnancy unlimited</b>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>ABA Treatment for Autism Spectrum Disorder</b>	<b>Covered in full after deductible</b>	<b>680 Hours Per Plan Year</b>
<b>Assistive Communication Devices for Autism Spectrum Disorder</b>	<b>Covered in full after deductible</b>	<b>Limited to dedicated devices</b>
<b>Diabetic Equipment, Supplies and Self-Management Education</b>		
<b>Diabetic Equipment, Supplies and Insulin (30-day; up to a</b>	<b>Covered in full after deductible</b>	<b>No limit</b>

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

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
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	<ul style="list-style-type: none"> <li>• Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</li> <li>• Partial reimbursement for facility fees every 6 months if member attains at least 50 visits</li> </ul>
<b>PEDIATRIC DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Pediatric Dental Care		
Preventive Dental Care	Covered in full after deductible	<p>One dental exam and cleaning per 6-month period</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals</p>
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

<b>Contact Lenses</b>	<b>Covered in full after deductible</b>	
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**Section II.E – HMO A-VAD Non-Standard Plan Benefit Description**

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

<b>Bone Density Testing*</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Screening for Prostate Cancer</b>	<b>\$15 Copayment</b>	<b>Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.</b>
<b>Family Planning Services for Women</b>	<b>Covered in full</b>	<b>No limit</b>
<b>All other preventive services required by USPSTF and HRSA.</b>	<b>Covered in full</b>	<b>No limit</b>
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Pre-Hospital Emergency Medical Services (Ambulance Services)</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Emergency Department</b>	<b>\$100 Copayment</b> <b>Copayment / Coinsurance waived if Hospital admission</b>	<b>No limit</b>
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Advanced Imaging Services</b>		
<b>Performed in a Freestanding Radiology Facility or Office Setting</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Allergy Testing and Treatment</b>		
<b>Performed in a PCP Office</b>	<b>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &amp; Diagnostic Procedures)</b>	<b>No limit</b>
<b>Performed in a Specialist Office</b>		
<b>Ambulatory Surgical Center Facility Fee</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Anesthesia Services (all settings)</b>	<b>Covered in full</b>	<b>No limit</b>

<b>Cardiac and Pulmonary Rehabilitation</b>		
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
<b>Chemotherapy</b>		
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)	
<b>Diagnostic Testing</b>		
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
<b>Dialysis</b>		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	

<b>Setting</b>		
<b>Performed as Outpatient Hospital Services</b>	<b>\$15 Copayment</b>	
<b>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>	<b>\$25 Copayment</b>	<b>60 visits per condition, per lifetime combined therapies</b>
<b>Home Health Care</b>	<b>\$15 Copayment</b>	<b>40 Visits per Plan Year</b>
<b>Infertility Services</b>	<b>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</b>	<ul style="list-style-type: none"> <li>• Member must be between ages of 21 and 44</li> <li>• Advanced infertility not covered</li> </ul>
<b>Infusion Therapy</b>		
<b>Performed in a PCP Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed in Specialist Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Home Infusion Therapy</b>	<b>\$15 Copayment</b>	<b>Home Infusion counts towards Home Health Care Visit Limits</b>
<b>Inpatient Medical Visits</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Laboratory Procedures</b>		
<b>Performed in a PCP Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed in a Freestanding Laboratory Facility or Specialist Office</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Maternity and Newborn Care</b>		
<b>Prenatal Care</b>	<b>Covered in full</b>	<b>No limit</b>

<b>Inpatient Hospital Services and Birthing Center</b>	<b>\$500 Copayment per admission</b>	<b>No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</b>
<b>Physician Midwife Services for Delivery</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Breast Pump</b>	<b>Covered in full</b>	<b>Covered for duration of breast feeding</b>
<b>Postnatal Care</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery Facility Charge</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Diagnostic Radiology Services</b>		
<b>Performed in a PCP Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$35 Copayment</b>	<b>No limit</b>
<b>Therapeutic Radiology Services</b>		
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>	<b>\$25 Copayment</b>	<b>60 visits per condition, per lifetime combined therapies  Speech and Physical Therapy are only Covered following a Hospital stay or surgery.</b>

<b>Second Opinions on the Diagnosis of Cancer, Surgery and Other</b>	<b>\$35 Copayment</b>	<b>One second surgical opinion on the need for surgery</b>  <b>For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer</b>
<b>Surgical Services</b>		<b>No limit</b>  <b>Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational.</b>  <b>Oral Surgery due to injury is limited to sound and natural teeth only.</b>
<b>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Inpatient Hospital Surgery</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Surgery Performed at an Ambulatory Surgical Center</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Office Surgery</b>	<b>Cost sharing determined by provider type, whether PCP or SPC</b>	<b>No limit</b>
<b>Elective Termination of Pregnancy</b>	<b>\$100 Copayment</b>	<b>1 Treatment per Year; Therapeutic termination of pregnancy unlimited</b>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>ABA Treatment for Autism Spectrum Disorder</b>	<b>\$15 Copayment</b>	<b>680 Hours Per Plan Year</b>

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	\$0 copay	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

<b>Bariatric Surgery</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)</b>	<b>\$500 Copayment per admission</b>	<b>200 Days Per Plan Year</b>
<b>Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)</b>	<b>\$500 Copayment per admission</b>	<b>60 Consecutive Days Per Condition, Per Lifetime</b>
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Inpatient Mental Health Care (for a continuous confinement when in a Hospital)</b>	<b>\$500 Copayment per admission</b>	<b>No limit</b>
<b>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</b>	<b>\$15 Copayment</b>	<b>No limit</b>
<b>Inpatient Substance Use Services (for a continuous confinement when in a Hospital)</b>	<b>\$500 Copayment per admission Preauthorization is Not Required for Emergency Admissions</b>	<b>No limit</b>
<b>Outpatient Substance Use Services</b>	<b>\$15 Copayment</b>	<b>No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling</b>
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Retail Pharmacy</b>		
<b>30-day supply</b>		
<b>Tier 1</b>	<b>\$10 Copayment</b>	<b>No limit</b>
<b>Tier 2</b>	<b>\$30 Copayment</b>	<b>No limit</b>
<b>Tier 3</b>	<b>\$60 Copayment</b>	<b>No limit</b>
<b>Up to a 90-day supply for Maintenance Drugs</b>		

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 Copayment	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	<ul style="list-style-type: none"> <li>• Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</li> <li>• Partial reimbursement for facility fees every 6 months if member attains at least 50 visits</li> </ul>
<b>DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Dental Care		
Preventive Dental Care	\$15 Copayment	<p>One dental exam and cleaning per 6-month period</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals</p>
Routine Dental Care	\$15 Copayment	
Major Dental (Endodontics, Periodontics and	\$15 Copayment	

<b>Prosthodontics)</b>		
<b>Orthodontics</b>	<b>\$15 Copayment</b>	
<b>Vision Care</b>		
<b>Exams</b>	<b>\$15 Copayment</b>	<b>One Exam Per 12-Month Period</b>
<b>Lenses and Frames</b>	<b>10% Coinsurance</b>	<b>One Prescribed Lenses &amp; Frames in a 12-Month Period</b>
<b>Contact Lenses</b>	<b>10% Coinsurance</b>	

**Section II.F – HMO B-VAD Non-Standard Plan Benefit Description**

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

Vasectomy	\$25 Copayment after deductible	No limit
Bone Density Testing*	Covered in full	No limit
Screening for Prostate Cancer	\$25 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
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Advanced Imaging Services</b>		
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
<b>Allergy Testing and Treatment</b>		
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

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

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)	<ul style="list-style-type: none"> <li>• Member must be between ages of 21 and 44</li> <li>• Advanced infertility not covered</li> </ul>
<b>Infusion Therapy</b>		
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
<b>Laboratory Procedures</b>		
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
<b>Maternity and Newborn Care</b>		
Prenatal Care	Covered in full	No limit

<b>Inpatient Hospital Services and Birthing Center</b>	<b>\$1,000 Copayment per admission after deductible</b>	<b>No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</b>
<b>Physician Midwife Services for Delivery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Breast Pump</b>	<b>Covered in full</b>	<b>Covered for duration of breast feeding</b>
<b>Postnatal Care</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery Facility Charge</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Diagnostic Radiology Services</b>		
<b>Performed in a PCP Office</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$40 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$40 Copayment after deductible</b>	<b>No limit</b>
<b>Therapeutic Radiology Services</b>		
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>\$25 Copayment after deductible</b>	<b>No limit</b>
<b>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>	<b>\$30 Copayment after deductible</b>	<b>60 visits per condition, per lifetime combined therapies</b>  <b>Speech and Physical Therapy are only Covered following a Hospital stay or surgery.</b>

<b>Second Opinions on the Diagnosis of Cancer, Surgery and Other</b>	<b>\$40 Copayment after deductible</b>	<b>One second surgical opinion on the need for surgery</b>  <b>For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer</b>
<b>Surgical Services</b>		<b>No limit</b>  <b>Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational.</b>  <b>Oral Surgery due to injury is limited to sound and natural teeth only.</b>
<b>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</b>	<b>\$100 Copayment</b>	<b>No limit</b>
<b>Inpatient Hospital Surgery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Surgery Performed at an Ambulatory Surgical Center</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Office Surgery</b>	<b>Cost sharing determined by provider type, whether PCP or SPC</b>	<b>No limit</b>
<b>Elective Termination of Pregnancy</b>	<b>\$100 Copayment</b>	<b>1 Treatment per Year; Therapeutic termination of pregnancy unlimited</b>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>ABA Treatment for Autism Spectrum Disorder</b>	<b>\$25 Copayment after deductible</b>	<b>680 Hours Per Plan Year</b>

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	\$0 copay 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 (Physical, Speech and Occupational therapy)	\$1,000 Copayment per admission after deductible	60 Consecutive Days Per Condition, Per Lifetime
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Retail Pharmacy		
30-day supply		
Tier 1	\$10 Copayment	No limit
Tier 2	\$35 Copayment	No limit
Tier 3	\$70 Copayment	No limit

<b>Up to a 90-day supply for Maintenance Drugs</b>		
<b>Tier 1</b>	<b>\$30 Copayment</b>	<b>No limit</b>
<b>Tier 2</b>	<b>\$105 Copayment</b>	<b>No limit</b>
<b>Tier 3</b>	<b>\$210 Copayment</b>	<b>No limit</b>
<b>Mail Order Pharmacy</b>		
<b>Up to a 90-day supply</b>		
<b>Tier 1</b>	<b>\$25 Copayment</b>	<b>No limit</b>
<b>Tier 2</b>	<b>\$88 Copayment</b>	<b>No limit</b>
<b>Tier 3</b>	<b>\$175 Copayment</b>	<b>No limit</b>
<b>Enteral Formulas</b>	<b>\$10 Copayment</b>	<b>No limit</b>
<b>Off Label Cancer Drugs</b>	<b>Use appropriate prescription drug tier cost-sharing</b>	<b>30 day supply per month</b>
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Gym Reimbursement</b>	<b>Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</b>	<ul style="list-style-type: none"> <li>• <b>Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</b></li> <li>• <b>Partial reimbursement for facility fees every 6 months if member attains at least 50 visits</b></li> </ul>
<b>DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Dental Care</b>		
<b>Preventive Dental Care</b>	<b>\$25 Copayment after deductible</b>	<b>One dental exam and cleaning per 6-month period</b>  <b>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals</b>
<b>Routine Dental Care</b>	<b>\$25 Copayment after deductible</b>	

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

## Section II.G – HMO C-VAD Non-Standard Plan Benefit Description

Healthfirst HMO C-VAD Non-Standard Benefits		
COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Limits
<b>Deductible</b>		
· Individual	\$2,000	
· Family	\$4,000	
<b>Out-of-Pocket Limit</b>		
· Individual	\$5,500	
· Family	\$11,000	
<b>OFFICE VISITS</b>	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
<b>PREVENTIVE CARE</b>	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	\$30 Copayment after deductible	No limit
Bone Density Testing*	Covered in full	No limit

Screening for Prostate Cancer	\$30 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
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Advanced Imaging Services</b>		
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
<b>Allergy Testing and Treatment</b>		
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
<b>Cardiac and Pulmonary</b>		

<b>Rehabilitation</b>		
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
<b>Chemotherapy</b>		
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)	
<b>Diagnostic Testing</b>		
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
<b>Dialysis</b>		<b>Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year</b>
Performed in a PCP Office	\$30 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office Setting	\$30 Copayment after deductible	

Performed as Outpatient Hospital Services	\$30 Copayment after deductible	
Habilitation Services	\$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
(Physical Therapy, Occupational Therapy or Speech Therapy)		
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)	<ul style="list-style-type: none"> <li>• Member must be between ages of 21 and 44</li> <li>• Advanced infertility not covered</li> </ul>
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
<b>Diagnostic Radiology Services</b>		
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
<b>Therapeutic Radiology Services</b>		
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

<b>Surgical Services</b>		<b>No limit</b>  <b>Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational.</b>  <b>Oral Surgery due to injury is limited to sound and natural teeth only.</b>
<b>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Inpatient Hospital Surgery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Surgery Performed at an Ambulatory Surgical Center</b>	<b>\$100 Copayment after deductible</b>	<b>No limit</b>
<b>Office Surgery</b>	<b>Cost sharing determined by provider type, whether PCP or SPC</b>	<b>No limit</b>
<b>Elective Termination of Pregnancy</b>	<b>\$100 Copayment</b>	<b>1 Treatment per Year; Therapeutic termination of pregnancy unlimited</b>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>ABA Treatment for Autism Spectrum Disorder</b>	<b>\$30 Copayment after deductible</b>	<b>680 Hours Per Plan Year</b>
<b>Assistive Communication Devices for Autism Spectrum Disorder</b>	<b>\$30 Copayment after deductible</b>	<b>Limited to dedicated devices</b>
<b>Diabetic Equipment, Supplies and Self-Management Education</b>		

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
<b>Hospice Care</b>		
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	\$0 copay after deductible	No limit
<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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	\$10 Copayment	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	<ul style="list-style-type: none"> <li>• Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</li> <li>• Partial reimbursement for facility fees every 6 months if member attains at least 50 visits</li> </ul>
<b>DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
Dental Care		
Preventive Dental Care	\$30 Copayment after deductible	<p>One dental exam and cleaning per 6-month period</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals</p>
Routine Dental Care	\$30 Copayment after deductible	
Major Dental (Endodontics, Periodontics and Prosthodontics)	\$30 Copayment after deductible	
Orthodontics	\$30 Copayment after deductible	
Vision Care		

<b>Exams</b>	<b>\$30 Copayment after deductible</b>	<b>One Exam Per 12-Month Period</b>
<b>Lenses and Frames</b>	<b>30% Coinsurance after deductible</b>	<b>One Prescribed Lenses &amp; Frames in a 12-Month Period</b>
<b>Contact Lenses</b>	<b>30% Coinsurance after deductible</b>	

**Section II.H – HMO D-VAD Non-Standard Plan Benefit Description**

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

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
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Advanced Imaging Services</b>		
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
<b>Allergy Testing and Treatment</b>		
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 Setting	50% Coinsurance after deductible	
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)	<ul style="list-style-type: none"> <li>• Member must be between ages of 21 and 44</li> <li>• Advanced infertility not covered</li> </ul>
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

<b>Inpatient Hospital Services and Birthing Center</b>	<b>50% Coinsurance after deductible</b>	<b>No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</b>
<b>Physician Midwife Services for Delivery</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Breast Pump</b>	<b>Covered in full</b>	<b>Covered for duration of breast feeding</b>
<b>Postnatal Care</b>	<b>Covered in full</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery Facility Charge</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Diagnostic Radiology Services</b>		
<b>Performed in a PCP Office</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Therapeutic Radiology Services</b>		
<b>Performed in a Freestanding Radiology Facility or Specialist Office</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Performed as Outpatient Hospital Services</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>	<b>50% Coinsurance after deductible</b>	<b>60 visits per condition, per lifetime combined therapies</b>  <b>Speech and Physical Therapy are only Covered following a Hospital stay or surgery.</b>

<b>Second Opinions on the Diagnosis of Cancer, Surgery and Other</b>	<b>50% Coinsurance after deductible</b>	<b>One second surgical opinion on the need for surgery</b>  <b>For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer</b>
<b>Surgical Services</b>		<b>No limit</b>  <b>Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational.</b>  <b>Oral Surgery due to injury is limited to sound and natural teeth only.</b>
<b>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Inpatient Hospital Surgery</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Outpatient Hospital Surgery</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Surgery Performed at an Ambulatory Surgical Center</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Office Surgery</b>	<b>50% Coinsurance after deductible</b>	<b>No limit</b>
<b>Elective Termination of Pregnancy</b>	<b>50% Coinsurance after deductible</b>	<b>1 Treatment per Year; Therapeutic termination of pregnancy unlimited</b>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>ABA Treatment for Autism Spectrum Disorder</b>	<b>50% Coinsurance after deductible</b>	<b>680 Hours Per Plan Year</b>

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
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	
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	\$10 Copayment	No limit
Off Label Cancer Drugs	50% Coinsurance after deductible	30 day supply per month
<b>WELLNESS BENEFITS</b>	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	<ul style="list-style-type: none"> <li>• Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse</li> <li>• Partial reimbursement for facility fees every 6 months if member attains at least 50 visits</li> </ul>
<b>DENTAL and VISION CARE</b>	Participating Provider Member Responsibility for Cost-Sharing	
Dental Care		
Preventive Dental Care	50% Coinsurance after deductible	<p>One dental exam and cleaning per 6-month period</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals</p>
Routine Dental Care	50% Coinsurance after deductible	
Major Dental (Endodontics, Periodontics and Prosthodontics)	50% Coinsurance after deductible	

<b>Orthodontics</b>	<b>50% Coinsurance after deductible</b>	
<b>Vision Care</b>		
<b>Exams</b>	<b>50% Coinsurance after deductible</b>	<b>One Exam Per 12-Month Period</b>
<b>Lenses and Frames</b>	<b>50% Coinsurance after deductible</b>	<b>One Prescribed Lenses &amp; Frames in a 12-Month Period</b>
<b>Contact Lenses</b>	<b>50% Coinsurance after deductible</b>	

## **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.