

MANAGED HEALTH, INC.

Rate Manual Pursuant to New York Insurance Law Section 3231(d)

Healthy NY

Small Group HMO Rates and Forms Submission

Effective January 1, 2015

TABLE OF CONTENTS

I.	Healthy NY Small Group HMO Plan Rates.....	4
	A. Rate Pages	5
	B. Description of Rating Classes, Factors, and Premium Discounts.....	7
	C. Rate Calculation Examples.....	9
	D. Expected Loss Ratio(s).....	11
II.	Description of Benefits, Types of Coverage, Limitations, Exclusions, Issue Limits, and Renewal Conditions.....	12
	A. Healthfirst Healthy NY Small Group HMO (with Family Planning).....	13
	B. Healthfirst Healthy NY Small Group HMO (without Family Planning).....	22
III.	Underwriting Guidelines.....	31

**SECTION I –
Healthy NY Small Group HMO
Premium Rates**

Section I.A – Rate Pages

MANAGED HEALTH, INC.

HEALTHY NY SMALL GROUP HMO

RATE PAGES - EFFECTIVE JANUARY 1, 2015

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

PROPOSED HMO PREMIUM RATES (WITH FAMILY PLANNING)

January – December, 2015

HEALTHFIRST HEALTHY NY	Monthly Premium	Added Cost of Age 29 Rider	Added Cost of Domestic Partner Rider
<i>Single</i>	\$526.46	\$17.55	\$0.00
<i>Single + spouse</i>	\$1,052.92	\$35.10	\$0.00
<i>Single + child(ren)</i>	\$894.99	\$29.83	\$0.00
<i>Single + spouse + child(ren)</i>	\$1,500.41	\$50.03	\$0.00

Form Numbers of policies to which these rates apply:

<i>Healthfirst Healthy NY</i>
MHI-HNY-SG-15
MHI-HNY-SG-SoB-15
MHI-DPR-15
MHI-A29R-15

**MANAGED HEALTH, INC.
HEALTHY NY SMALL GROUP HMO
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, AND SUFFOLK COUNTIES**

PROPOSED HMO PREMIUM RATES (WITHOUT FAMILY PLANNING)

January – December, 2015

HEALTHFIRST HEALTHY NY	Monthly Premium	Added Cost of Age 29 Rider	Added Cost of Domestic Partner Rider
<i>Single</i>	\$522.02	\$17.40	\$0.00
<i>Single + spouse</i>	\$1,044.04	\$34.80	\$0.00
<i>Single + child(ren)</i>	\$887.43	\$29.59	\$0.00
<i>Single + spouse + child(ren)</i>	\$1,487.76	\$49.59	\$0.00

Form Numbers of policies to which these rates apply:

<i>Healthfirst Healthy NY</i>
MHI-HNY-SG-15
MHI-HNY-SG-SoB-15
MHI-DPR-15
MHI-A29R-15
MHI-FPR-15

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

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

Family/Census Tier

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

Rating Region

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

Family Planning Benefits

Family Planning Rider	Cost Factor
Included	1.000
Not Included	0.992

Dependent Age Limit

Dependent Age Limit	Cost Factor
26	1.000
29	1.033

Domestic Partner Coverage

Domestic Partner	Cost Factor
Covered	1.000
Not Covered	1.000

Section I.C – Rate Calculation Examples

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

EXAMPLE:

Consumer Profile: A married employee (subscriber), of a Queens County-based employer, who is electing to cover his spouse and two children as dependents, is choosing the Healthfirst Healthy NY product with pediatric dental benefits and family planning benefits, and not choosing the Age 29 Rider.

Rate Look-Up Solution: There are no differences in premium rates for the two different rating regions included in this product (Regions 4 and 8), therefore the subscriber is advised to proceed to page 5 and refer to the first table under the heading "Proposed HMO Premium Rates – Standard Plans (With Family Planning)." Next, the consumer would refer to the column labeled, "Healthfirst Healthy NY" and cross-reference the row labeled, "Single + Spouse + Child(ren)." The rate for this plan is \$1,553.06 per month.

Section I.D – Expected Loss Ratios

For the plans listed in this rate manual, the projected loss ratio using the Federally prescribed medical loss ratio (MLR) methodology is 84.5%. The expected loss ratio under New York State's MLR methodology is 82.3%. These projected loss ratios are greater than the Federally prescribed 80% minimum for Individual products, as well as the 82% minimum prescribed by New York State for Individual products.

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

Section II.A – Healthy NY Small Group HMO Gold Benefit Description (with Family Planning)

Healthfirst Healthy New York (with Family Planning)		
COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Limits
Deductible		
Individual	\$600	
Family	\$1,200	
Out-of-Pocket Limit		
Individual	\$4,000	
Family	\$8,000	
OFFICE VISITS	Participating Provider Member Responsibility for Cost-Sharing	
Primary Care Office Visits (or home visits)	\$25 Copayment	No limit
Specialist Office Visits (or home visits)	\$40 Copayment	No limit
PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	
Well Child Visits and Immunizations	Covered in full	No limit
Adult Annual Physical Examinations	Covered in full	No limit
Adult Immunizations	Covered in full	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full	No limit
Mammography Screenings	Covered in full	No limit
Sterilization Procedures for Women*	Covered in full	No limit
Vasectomy	\$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
EMERGENCY CARE	Participating Provider Member Responsibility for Cost-Sharing	
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment after deductible	No limit
Emergency Department	\$150 Copayment after deductible	No limit
	Copayment / Coinsurance waived if Hospital admission	No limit
PROFESSIONAL SERVICES and OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	\$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$40 Copayment after deductible	No limit
Allergy Testing and Treatment		
Performed in a PCP Office	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	\$100 Copayment after deductible	No limit
Anesthesia Services (all settings)	Covered in full	No limit
Cardiac and Pulmonary Rehabilitation		

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

Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	\$25 Copayment after deductible	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	<ul style="list-style-type: none"> • Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		
Performed in a PCP Office	\$25 Copayment after deductible	No limit
Performed in Specialist Office	\$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$25 Copayment after deductible	No limit
Home Infusion Therapy	\$25 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	\$25 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	\$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$40 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit
Inpatient Hospital Services and Birthing Center	\$1,000 Copayment per admission after deductible	No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Physician Midwife Services for Delivery	\$100 Copayment after deductible	No limit
Breast Pump	Covered in full	Covered for duration of breast

		feeding
Postnatal Care	Covered in full	No limit
Outpatient Hospital Surgery Facility Charge	\$100 Copayment after deductible	No limit
Diagnostic Radiology Services		
Performed in a PCP Office	\$25 Copayment after deductible	No limit
Performed in a Freestanding Radiology Facility or Specialist Office	\$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$40 Copayment after deductible	No limit
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	\$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$25 Copayment after deductible	No limit
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery and Other	\$40 Copayment after deductible	One second surgical opinion on the need for surgery For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer

Surgical Services		No limit Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. Oral Surgery due to injury is limited to sound and natural teeth only.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	\$100 Copayment	No limit
Inpatient Hospital Surgery	\$100 Copayment after deductible	No limit
Outpatient Hospital Surgery	\$100 Copayment after deductible	No limit
Surgery Performed at an Ambulatory Surgical Center	\$100 Copayment after deductible	No limit
Office Surgery	Cost sharing determined by provider type, whether PCP or SPC	No limit
Elective Termination of Pregnancy	\$100 Copayment	1 Treatment per Year; Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	\$25 Copayment after deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	\$25 Copayment after deductible	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	\$25 Copayment after deductible	No limit

Diabetic Education	\$25 Copayment after deductible	No limit
Durable Medical Equipment and Braces	20% Coinsurance after deductible	Coverage for standard equipment only.
External Hearing Aids	20% Coinsurance after deductible	Single Purchase Once Every 3 Years
Cochlear Implants	20% Coinsurance after deductible	One Per Ear Per Time Covered
Hospice Care		
Inpatient	\$1,000 Copayment per admission after deductible	210 Days per Plan Year
Outpatient	\$25 Copayment after deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance after deductible	
Prosthetic Devices		
External	20% Coinsurance after deductible	One prosthetic device, per limb, per lifetime
Internal	\$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

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	\$25 Copayment after deductible	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	\$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Substance Use Services	\$25 Copayment after deductible	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	
Retail Pharmacy		
30-day supply		
Tier 1	\$10 Copayment	No limit
Tier 2	\$35 Copayment	No limit
Tier 3	\$70 Copayment	No limit
Up to a 90-day supply for Maintenance Drugs		
Tier 1	\$30 Copayment	No limit
Tier 2	\$105 Copayment	No limit
Tier 3	\$210 Copayment	No limit
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	\$25 Copayment	No limit

Tier 2	\$88 Copayment	No limit
Tier 3	\$175 Copayment	No limit
Enteral Formulas	\$10 Copayment	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	<ul style="list-style-type: none"> • Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC DENTAL and VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	
Pediatric Dental Care		
Preventive Dental Care	\$25 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	\$25 Copayment after deductible	
Major Dental (Endodontics, Periodontics and Prosthodontics)	\$25 Copayment after deductible	
Orthodontics	\$25 Copayment after deductible	
Pediatric Vision Care		
Exams	\$25 Copayment after deductible	One Exam Per 12-Month Period
Lenses and Frames	20% Coinsurance after deductible	One Prescribed Lenses & Frames in a 12-Month Period
Contact Lenses	20% Coinsurance after deductible	

Section II.B – Healthy NY Small Group HMO Gold Benefit Description
(without Family Planning)

Healthfirst Healthy New York (without Family Planning)		
COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Limits
Deductible		
Individual	\$600	
Family	\$1,200	
Out-of-Pocket Limit		
Individual	\$4,000	
Family	\$8,000	
OFFICE VISITS	Participating Provider Member Responsibility for Cost-Sharing	
Primary Care Office Visits (or home visits)	\$25 Copayment	No limit
Specialist Office Visits (or home visits)	\$40 Copayment	No limit
PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	
Well Child Visits and Immunizations	Covered in full	No limit
Adult Annual Physical Examinations	Covered in full	No limit
Adult Immunizations	Covered in full	No limit
Routine Gynecological Services/Well Woman Exams	Covered in full	No limit
Mammography Screenings	Covered in full	No limit
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.
All other preventive services required by USPSTF and HRSA.	Covered in full	No limit
EMERGENCY CARE	Participating Provider Member Responsibility for Cost-Sharing	
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment after deductible	No limit
Emergency Department	\$150 Copayment after deductible	No limit
	Copayment / Coinsurance waived if Hospital admission	No limit
PROFESSIONAL SERVICES and OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	\$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$40 Copayment after deductible	No limit
Allergy Testing and Treatment		
Performed in a PCP Office	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	No limit
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	\$100 Copayment after deductible	No limit
Anesthesia Services (all settings)	Covered in full	No limit
Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	\$25 Copayment after deductible	No limit

Performed as Outpatient Hospital Services	\$25 Copayment after deductible	No limit
Performed as Inpatient Hospital Services	Included as part of inpatient hospital cost sharing	No limit
Chemotherapy		
Performed in a PCP Office	\$25 Copayment after deductible	No limit
Performed in a Specialist Office	\$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$25 Copayment after deductible	No limit
Chiropractic Services	\$40 Copayment after deductible	No limit
Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	
Diagnostic Testing		
Performed in a PCP Office	\$25 Copayment after deductible	No limit
Performed in a Specialist Office	\$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$40 Copayment after deductible	No limit
Dialysis		Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Performed in a PCP Office	\$25 Copayment after deductible	
Performed in a Freestanding Center or Specialist Office Setting	\$25 Copayment after deductible	
Performed as Outpatient Hospital Services	\$25 Copayment after deductible	
Habilitation Services	\$30 Copayment after deductible	60 visits per condition, per

(Physical Therapy, Occupational Therapy or Speech Therapy)		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"> • Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		
Performed in a PCP Office	\$25 Copayment after deductible	No limit
Performed in Specialist Office	\$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$25 Copayment after deductible	No limit
Home Infusion Therapy	\$25 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	\$25 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	\$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$40 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit
Inpatient Hospital Services and Birthing Center	\$1,000 Copayment per admission after deductible	No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Physician Midwife Services for Delivery	\$100 Copayment after deductible	No limit
Breast Pump	Covered in full	Covered for duration of breast feeding

Postnatal Care	Covered in full	No limit
Outpatient Hospital Surgery Facility Charge	\$100 Copayment after deductible	No limit
Diagnostic Radiology Services		
Performed in a PCP Office	\$25 Copayment after deductible	No limit
Performed in a Freestanding Radiology Facility or Specialist Office	\$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$40 Copayment after deductible	No limit
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	\$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	\$25 Copayment after deductible	No limit
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$30 Copayment after deductible	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery and Other	\$40 Copayment after deductible	One second surgical opinion on the need for surgery For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer

Surgical Services		No limit Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. Oral Surgery due to injury is limited to sound and natural teeth only.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	\$100 Copayment	No limit
Inpatient Hospital Surgery	\$100 Copayment after deductible	No limit
Outpatient Hospital Surgery	\$100 Copayment after deductible	No limit
Surgery Performed at an Ambulatory Surgical Center	\$100 Copayment after deductible	No limit
Office Surgery	Cost sharing determined by provider type, whether PCP or SPC	No limit
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	\$25 Copayment after deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	\$25 Copayment after deductible	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	\$25 Copayment after deductible	No limit
Diabetic Education	\$25 Copayment after deductible	No limit

Durable Medical Equipment and Braces	20% Coinsurance after deductible	Coverage for standard equipment only.
External Hearing Aids	20% Coinsurance after deductible	Single Purchase Once Every 3 Years
Cochlear Implants	20% Coinsurance after deductible	One Per Ear Per Time Covered
Hospice Care		
Inpatient	\$1,000 Copayment per admission after deductible	210 Days per Plan Year
Outpatient	\$25 Copayment after deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance after deductible	
Prosthetic Devices		
External	20% Coinsurance after deductible	One prosthetic device, per limb, per lifetime
Internal	\$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
MENTAL HEALTH and SUBSTANCE USE DISORDER	Participating Provider Member Responsibility for Cost-Sharing	

SERVICES		
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	\$25 Copayment after deductible	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	\$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Substance Use Services	\$25 Copayment after deductible	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	
Retail Pharmacy		
30-day supply		
Tier 1	\$10 Copayment	No limit
Tier 2	\$35 Copayment	No limit
Tier 3	\$70 Copayment	No limit
Up to a 90-day supply for Maintenance Drugs		
Tier 1	\$30 Copayment	No limit
Tier 2	\$105 Copayment	No limit
Tier 3	\$210 Copayment	No limit
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	\$25 Copayment	No limit
Tier 2	\$88 Copayment	No limit

Tier 3	\$175 Copayment	No limit
Enteral Formulas	\$10 Copayment	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	<ul style="list-style-type: none"> • Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC DENTAL and VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	
Pediatric Dental Care		
Preventive Dental Care	\$25 Copayment after deductible	One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals
Routine Dental Care	\$25 Copayment after deductible	
Major Dental (Endodontics, Periodontics and Prosthodontics)	\$25 Copayment after deductible	
Orthodontics	\$25 Copayment after deductible	
Pediatric Vision Care		
Exams	\$25 Copayment after deductible	One Exam Per 12-Month Period
Lenses and Frames	20% Coinsurance after deductible	One Prescribed Lenses & Frames in a 12-Month Period
Contact Lenses	20% Coinsurance after deductible	

SECTION III – Underwriting Guidelines

HEALTHFIRST PARTICIPATION AND ELIGIBILITY GUIDELINES

New York Small Groups (1 – 50 Employees)

Off-Exchange Products

The following participation and eligibility guidelines apply to employer groups enrolling in or renewing coverage in Healthfirst Small Group Off-Exchange products.

Section 1: Small Group Eligibility

- A. The employer must actively operate a business with a street address in a county where Healthfirst offers small group products (Bronx, Kings, Nassau, New York, Queens, Richmond, and Suffolk counties).
- B. If the employer does not offer group health coverage to all eligible employees, group size will be calculated based on the number of eligible employees in Healthfirst's service area.
- C. A minimum of 60% of all eligible employees after valid waivers must be enrolled. The 60% threshold will be determined by multiplying the number of eligible employees by 0.60 and rounding fractions down to the nearest whole number. Valid waivers include:
 - a. Spousal coverage
 - b. Medicare coverage
 - c. Medicaid coverage
 - d. VA coverage
 - e. TriCare coverage
 - f. ACA-compliant plan coverage

****This requirement does not apply to HMO plans.***

- D. If the group offers retiree coverage, a minimum of 60% of all eligible employees after valid waivers and all eligible former retired employees must be enrolled. (Additional documentation may be required on audit to confirm retirees' eligibility for coverage).

****This requirement does not apply to HMO plans.***

- E. **Valid Employer Class(es):** An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic status of employment, earnings, method of compensation, hours and occupational duties. (**Example:** Employer may elect to offer coverage only to employees who work at least 30 hours per week.)
- F. **Out-of-Area:** Out-of-area enrollment is not allowed on Healthfirst small group plans. Eligible employees who neither work nor reside in HF's service area (Bronx, Kings, Nassau, New York, Queens, Richmond, and Suffolk counties) may not be covered on Healthfirst small group products.

G. Two Life Group: A two life group consisting of a husband and wife is considered to be a sole proprietor per Federal guidelines, and is not eligible for small group coverage

H. Minimum Participation – Calculation (for plans other than HMOs):

Pursuant to federal regulations, Healthfirst will have an open enrollment period from November 15th through December 15th for all small groups that do not meet minimum participation requirements. The coverage effective date for small groups enrolling during this period will be January 1st.

Section 2: Employee Eligibility

A. Eligible employees, and if the group offers retiree benefits, all eligible retired former employees, can be enrolled in Healthfirst small group products if they:

- a. Live in the Healthfirst service area.
- b. Are active full-time employees of the employer, and of all subsidiaries and affiliates of a corporate employer, that work at least 20 hours or more per week. The employer must have at least two such employees to remain active.

B. Eligible dependents are defined as: a legally married spouse or domestic partner, and a legally dependent child up to the age of 26. Additional options for age 29 are also available. Domestic partners will be required to submit a domestic partner eligibility attestation. Marriage and birth certificates may be required to prove family eligibility. A copy of a filed Federal Form 1040 may be required for married couples or dependents with a different last name than the employee.

C. The following are **not** counted as eligible employees when determining group size and are excluded from eligibility and coverage:

- a. COBRA-only former employees
- b. Consultants and independent contractors (1099 employees)
- c. Directors and officers who do not qualify as owners, partners or employees
- d. Foreign employees covered by their country's government health insurance
- e. Leased employees are ineligible for coverage
- f. Part-time, temporary and seasonal workers that are not hired to work a full year

Section 3: Employee Required Information

A. The following information on enrolled employees and their dependents is required before processing:

- a. Social security number for each subscriber
- b. Date(s) of birth for all subscribers and dependents
- c. Complete street address
- d. Date of marriage (if applicable)
- e. Employment effective (start) date
- f. Employer and employee signatures

Section 4: Employer Tax Documentation

- A. The most recent NYS-45 (NYS Quarterly Combined Withholding and Wage Report). If not required to file the NYS-45, then one of the following is required:
- B. If a “C” corporation: Articles of incorporation, Form 1120 (line 13 is wages) and payroll documents
- C. If a Church: Form 941 (line 2 is wages) and payroll documents
- D. If a LLC: LLC agreement and the appropriate documentation noted above
- E. If a Partnership: K-1 or Form 1065 (line 9 is wages) and payroll documents and business license
- F. If an “S” corporation: Articles of incorporation, Form 1120S (line 8 is wages) and payroll documents
- G. Newly formed business: If the business has been in existence less than one year and has not yet filed a Quarterly Wage and Tax Statement, HF will accept Corporation or Partnership papers and payroll documents
- H. A federal TIN or additional documentation may be required upon audit.

Section 5: Required Documentation for Effectuation

- A. All paperwork for new business must be received 30 days in advance of the requested effectuation date. New business will have an effective date of the 1st of the month.
- B. All paperwork for renewing business must be received 30 days in advance of the requested renewal date.
- C. Paperwork required:
 - a. Signed group application
 - b. Fully completed original employee enrollment forms and waiver forms (if applicable)
 - c. Check for the first month’s premium from the employer’s business account

Section 6: Submit Application & Payment

- A. New business must be submitted at least 30 days before the effective date.
- B. Incomplete application packages may delay a group’s effective date.

Mailing address:

Healthfirst
Enrollment Intake Department
100 Church Street
New York, NY 10007

- C. Please fill out application completely and include member and dependent information.

- New groups should submit the first month's premium on a company check.
- Payment may be remitted via bank check or money order. (Please be sure the name of the company or organization is clearly written when sending in bank check or money orders so that payment can be properly applied.)

Section 7: Enrollment and Waiting Periods

- A. Open enrollment will be held once a year on the group's anniversary or renewal date.
- B. Employee waiting periods for coverage effectiveness cannot exceed 90 days.
- C. New employees will be able to enroll in the plan on the first of the month following the plan's waiting period. A copy of the employee's W-4 or recent payroll check stub must be supplied to qualify for provisional enrollment in the event that the new employee is not yet listed on filed tax documentation. The payroll date cannot be more than 30 days prior to the date of application. The employer must produce tax documents within 90 days after the effective date of coverage to substantiate a new hire's eligibility.
- D. Employees who are terminated will be covered until the last day of the month in which the termination occurred. All terminations must be submitted either on a completed termination form or on company letterhead.
- E. Eligible employees who decline coverage and subsequently wish to enroll without a qualifying event will only be eligible to enroll during the next annual open enrollment period. A qualifying event is an unexpected event that will terminate an employee's participation in another health plan. An example of a qualifying event is the loss of coverage through a spouse who's losing a job.

Section 8: Rates and Rating Tiers

- A. Only 4-tier rates are available.
- B. Premium rates for Healthfirst Small Group products are based on employer location.
- C. Changes in group eligibility, rate structure, and benefits may be made upon the group's renewal. Should an employer cease to qualify as a small group of between 1- 50 eligible employees, the group is required to promptly notify Healthfirst of this change pursuant to the group contract.

Section 9: Ongoing Small Group Verification

Healthfirst or a Healthfirst designated administrator may take periodic surveys of enrolled small groups to ensure that the group is actively operating its business and is still qualified to be enrolled in a community-rated product. The survey can include, but not be limited to, any or all of the following to verify continued eligibility:

1. The employer's most recently filed NYS-45 or NYS-ATT
2. Tax documentation as requested by HF and/or HF's designated administrators
3. Payroll information as requested by HF and/or HF's designated administrators