Filing at a Glance

Company:	Group Health Incorporated
Product Name:	GHI OFF Exchange Sm Grp
State:	New York
TOI:	H15G Group Health - Hospital/Surgical/Medical Expense
Sub-TOI:	H15G.003 Small Group Only
Filing Type:	Off Exchange NG Forms & Rates
Date Submitted:	05/30/2013
SERFF Tr Num:	GRPH-129013148
SERFF Status:	Assigned
State Tr Num:	2013050229
State Status:	IA Awaiting Initial Action
Co Tr Num:	2013 0530 GHI SMALL GROUP OFF EXCHANGE
Implementation Date Requested:	On Approval
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

General Information

Project Name: GHI Off Exchange Sm Grp
Project Number: HCR-OX-100 et al
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Association, Discretionary, Trust, Non Employer Group
Filing Status Changed: 05/31/2013
State Status Changed: 06/03/2013
Created By: [redacted]
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: GHI licensed to conduct the business of insurance in New York State ony.

Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: [redacted]

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

This filing is a form and rate submission intended for use in the off exchange small group marketplace. The forms are new and do not replace any forms and/or rates currently on file with DFS.

The enclosed forms and rates are for the community rated small group off-exchange only GHI EPO 6300 Bronze high deductible health plan (HDHP). The policy forms that comprise this new product include the following:

Certificate of Coverage: HCR-OX-100
Age 29 Rider: HCR-OXR-A29
Contraceptive Rider: HCR-OXR-CC
Application Form: 155-23-EMBLEMAPP-OX14
Master Small Group Contract: HCR-OX-GC1

The GHI EPO 6300 Bronze product utilizes GHI's long standing Tri-State provider network and will provide in-network only benefits with the exception of emergency care as described in the certificate of coverage. Note that the enclosed forms utilize DFS model language and layout almost exclusively with the exception of the application form 155-23-EMBLEMAPP-OX14 and the master small group contract form HCR-OX-GC1, which are not model forms, and minor deviationsfrom the model language and/or standard beneifts appear in contract form HCR-OX-100 wtih respect to the out of network Allowed Charge definition and in the visit and/or item caps for home health care, rehabilitative and habilitative therapies and adult prosthetics.

Importantly, the enclosed forms do NOT include the required pediatric dental benefit, which GHI intends (as indicated in the application and product checklist) to "bundle" with a stand-alone pediatric dental plan underwritten by DentCare Delivery Systems, an New York State Article 43 corporation, for entities that indicate that they have not purchased stand-alone pediatric dental coverage. GHI/EmblemHealth is still in negotiations with DentCare Delivery Systems with regard to this bundled offering; however, EmblemHealth has an existing contractual relationship with Dentcare Delivery Systems' affiliate HealthPlex IPA to provide a dental network and certain related claims adminsitrative services in connection with its goverment programs business.

Note that application Form 155-23-EMBLEMAPP-OX14 and Master Small Group Contract form HCR-OX-GC1 are NOT based upon any DFS model language and/or model forms. They are modified versions of a previously approved GHI master small group contract and small group application form. Riders HCR-OXR-A29 and HCR-OXR-CC utilize DFS model language in all respects. Certificate of Coverage form HCR-OX-100 also utilizes DFS model language, approach and model optional provisions with only few and minor exceptions (or where specifically permitted in the model language, such as in the Section entitled "Other Covered Services").

Please review the enclosed forms and associated rating materials at your earliest convenience. GHI will look forward to your comments and/or approval.

Thank you for your assistance.

Best regards,

[redacted]
Assistant General Counsel
EmblemHealth

Company and Contact

Filing Contact Information

[redacted]
EmblemHealth
55 Water Street
New York, NY 10041
[redacted] Phone]
[redacted] FAX]

Filing Company Information

Group Health Incorporated	CoCode: 55239	State of Domicile: New York
441 Ninth Avenue	Group Code: -99	Company Type:
New York, NY 10001	Group Name:	State ID Number:
[redacted] [Phone]	FEIN Number: 13-5511997	

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

State: New York **Filing Company:** Group Health Incorporated
TOI/Sub-TOI: H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only
Product Name: GHI OFF Exchange Sm Grp
Project Name/Number: GHI Off Exchange Sm Grp/HCR-OX-100 et al

1. Is a parallel product being submitted for another entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No; however, GHI is separately filing the same plan design for use in the indiviudal market (refer to GHI form DPC-OX-100, et al.).
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Article 43
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): No
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Form and Rate
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: No
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): No

SERFF Tracking #:	*GRPH-129013148*	***State Tracking #:***	*2013050229*	***Company Tracking #:***	*2013 0530 GHI SMALL GROUP OFF EXCHANGE*

State:	*New York*	***Filing Company:***	*Group Health Incorporated*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*GHI OFF Exchange Sm Grp*		
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Rate Information

Rate data applies to filing.

Filing Method:	New Product Filing
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Group Health Incorporated	New Product	0.000%	%				%	%

SERFF Tracking #:	*GRPH-129013148*	***State Tracking #:***	*2013050229*	***Company Tracking #:***	*2013 0530 GHI SMALL GROUP OFF EXCHANGE*

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Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		GHI SG Rate Manual 2014		New		GHI SG Rate Manual 2014_whole.pdf,

GHI
Rates Effective 1/1/2014

Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	Proposed Rates 2014Q1	2014Q2	2014Q3	2014Q4
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Downstate	Ind	$539.25	$555.97	$573.21	$590.98
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Downstate	Ind + Sp	$1,078.50	$1,111.93	$1,146.40	$1,181.94
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Downstate	Parent + Chld(rn)	$916.73	$945.15	$974.45	$1,004.66
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Downstate	Family	$1,536.86	$1,584.50	$1,633.62	$1,684.26
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Long Island	Ind	$580.85	$598.86	$617.42	$636.56
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Long Island	Ind + Sp	$1,161.70	$1,197.71	$1,234.84	$1,273.12
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Long Island	Parent + Chld(rn)	$987.45	$1,018.06	$1,049.62	$1,082.16
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Long Island	Family	$1,655.42	$1,706.74	$1,759.65	$1,814.20
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Albany	Ind	$504.19	$519.82	$535.93	$552.54
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Albany	Ind + Sp	$1,008.38	$1,039.64	$1,071.87	$1,105.10
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Albany	Parent + Chld(rn)	$857.12	$883.69	$911.08	$939.32
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Albany	Family	$1,436.94	$1,481.49	$1,527.42	$1,574.77
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Buffalo	Ind	$466.49	$480.95	$495.86	$511.23
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Buffalo	Ind + Sp	$932.98	$961.90	$991.72	$1,022.46
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Buffalo	Parent + Chld(rn)	$793.03	$817.61	$842.96	$869.09
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Buffalo	Family	$1,329.50	$1,370.71	$1,413.20	$1,457.01
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Mid-Hudson	Ind	$552.46	$569.59	$587.25	$605.45
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Mid-Hudson	Ind + Sp	$1,104.92	$1,139.17	$1,174.48	$1,210.89
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Mid-Hudson	Parent + Chld(rn)	$939.18	$968.29	$998.31	$1,029.26
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Mid-Hudson	Family	$1,574.51	$1,623.32	$1,673.64	$1,725.52
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Rochester	Ind	$455.70	$469.83	$484.39	$499.41
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Rochester	Ind + Sp	$911.40	$939.65	$968.78	$998.81
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Rochester	Parent + Chld(rn)	$774.69	$798.71	$823.47	$849.00
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Rochester	Family	$1,298.75	$1,339.01	$1,380.52	$1,423.32
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Syracuse	Ind	$488.05	$503.18	$518.78	$534.86
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Syracuse	Ind + Sp	$976.10	$1,006.36	$1,037.56	$1,069.72
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Syracuse	Parent + Chld(rn)	$829.69	$855.41	$881.93	$909.27
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Syracuse	Family	$1,390.94	$1,434.06	$1,478.52	$1,524.35
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Utica	Ind	$509.61	$525.41	$541.70	$558.49
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Utica	Ind + Sp	$1,019.22	$1,050.82	$1,083.40	$1,116.99
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Utica	Parent + Chld(rn)	$866.34	$893.20	$920.89	$949.44
Bronze	Standard	EmblemHealth Tri-State EPO HD6300	Off	0.58	Utica	Family	$1,452.39	$1,497.41	$1,543.83	$1,591.69

GHI
Rates Effective 1/1/2014

Metal Level	Standard Plan or Age 29	Product Name	On/Off Exchange	Metal AV Value	Region	Tier	Proposed Rates 2014Q1	2014Q2	2014Q3	2014Q4
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Downstate	Ind	$550.57	$567.64	$585.24	$603.38
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Downstate	Ind + Sp	$1,101.14	$1,135.28	$1,170.47	$1,206.75
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Downstate	Parent + Chld(rn)	$935.97	$964.99	$994.90	$1,025.74
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Downstate	Family	$1,569.12	$1,617.76	$1,667.91	$1,719.62
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Long Island	Ind	$593.05	$611.43	$630.38	$649.92
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Long Island	Ind + Sp	$1,186.10	$1,222.87	$1,260.78	$1,299.86
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Long Island	Parent + Chld(rn)	$1,008.19	$1,039.44	$1,071.66	$1,104.88
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Long Island	Family	$1,690.19	$1,742.59	$1,796.61	$1,852.30
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Albany	Ind	$514.78	$530.74	$547.19	$564.15
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Albany	Ind + Sp	$1,029.56	$1,061.48	$1,094.39	$1,128.32
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Albany	Parent + Chld(rn)	$875.13	$902.26	$930.23	$959.07
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Albany	Family	$1,467.12	$1,512.60	$1,559.49	$1,607.83
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Buffalo	Ind	$476.29	$491.05	$506.27	$521.96
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Buffalo	Ind + Sp	$952.58	$982.11	$1,012.56	$1,043.95
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Buffalo	Parent + Chld(rn)	$809.69	$834.79	$860.67	$887.35
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Buffalo	Family	$1,357.43	$1,399.51	$1,442.89	$1,487.62
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Mid-Hudson	Ind	$564.06	$581.55	$599.58	$618.17
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Mid-Hudson	Ind + Sp	$1,128.12	$1,163.09	$1,199.15	$1,236.32
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Mid-Hudson	Parent + Chld(rn)	$958.90	$988.63	$1,019.28	$1,050.88
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Mid-Hudson	Family	$1,607.57	$1,657.40	$1,708.78	$1,761.75
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Rochester	Ind	$465.27	$479.69	$494.56	$509.89
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Rochester	Ind + Sp	$930.54	$959.39	$989.13	$1,019.79
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Rochester	Parent + Chld(rn)	$790.96	$815.48	$840.76	$866.82
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Rochester	Family	$1,326.02	$1,367.13	$1,409.51	$1,453.20
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Syracuse	Ind	$498.30	$513.75	$529.68	$546.10
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Syracuse	Ind + Sp	$996.60	$1,027.49	$1,059.34	$1,092.18
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Syracuse	Parent + Chld(rn)	$847.11	$873.37	$900.44	$928.35
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Syracuse	Family	$1,420.16	$1,464.18	$1,509.57	$1,556.37
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Utica	Ind	$520.31	$536.44	$553.07	$570.22
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Utica	Ind + Sp	$1,040.62	$1,072.88	$1,106.14	$1,140.43
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Utica	Parent + Chld(rn)	$884.53	$911.95	$940.22	$969.37
Bronze	Age 29	EmblemHealth Tri-State EPO HD6300	Off	0.58	Utica	Family	$1,482.88	$1,528.85	$1,576.24	$1,625.10

GHI
Small Group Off Exchange Products
Form Name and Number

EmblemHealth Tri-State EPO HD6300 for SG

Form Name	**Form Number**
Certificate of Coverage	HCR-OX-100
Age 29 Rider	HCR-OXR-A29
Contraceptive Rider	HCR-OXR-CC

GHI
Small Group Off Exchange Products
Region and Area Factors

Region	Area Factor
Downstate	0.955
LongIsland	1.029
Albany	0.893
Buffalo	0.826
Mid_Hudson	0.979
Rochester	0.807
Syracuse	0.865
Utica	0.903

GHI
Small Group Off Exchange Products
Expected Loss Ratios

EmblemHealth Tri-State EPO HD6300	**88.2%**

OFF EXCHANGE: Underwritten: GHI	Bronze
Product Type:	**EPO**
Ind/Fam Deductible (Med/Hosp/Vision/Rx)	$6,300/$12,700 (per cal/yr.)
Ind/Fam Maximum OOP (incl Ded):	$6,300/$12,600
Rx included in Deductible:	Yes
Rx included in OOP maximum:	Yes
Q4 Deductible Carry Over	No
PCP Visit (injury or illness)	0% cost sharing per visit
Specialist Visit	0% cost sharing per visit
Inpatient Facility/SNF/Hospice	0% cost sharingper admission
Outpatient Facility - Surgery, including free-standing surgicenters	0% cost sharing per visit
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	0% cost sharing per visit
Emergency Room - Facility charge (INN/ONN)	0% cost sharing (waived if admitted as an inpatient)
Emergency room visit - Physician charge	0% cost sharing per visit
Urgent Care (INN)	0% cost sharing per visit
Observation Stay	0% cost sharing (waived if admitted as inpatient)
Anesthesia	0% cost sharing
Emergent Ambulance	0% cost sharing per visit
Non-Emergent Ambulance Hosp to Facility Transfer	Covered in Full
PT/OT/ST (Rehabilitative & Habilatative)	0% cost sharing per visit
DME/Medical Supplies	0% Coinsurance
Hearing Aids	0% Coinsurance
Eyewear	0% Coinsurance
Exercise Facility Reimbursement	**Subscriber reimbursed at the lesser of $200 or actual cost of membership per six-month period and 50 visits. Subscriber's spouse reimbursed at the lesser of $100 or actual cost of membership per six-month period and 50 visits.** *** Incentive not applied to OOP or Deductible**

SERVICE	LIMIT/Note	IP Fac	OP Fac	Prof
Outpatient Services				
PCP Office Visits (Injury or Illness)	No Limit	N/A	N/A	0% Cost Sharing
Specialist Visits	No Limit	N/A	N/A	0% Cost Sharing
Outpatient Facility or Ambulatory Surgery	No Limit	N/A	OP Fac cost sharing on surgeries done in AmSurg or OP Facility.	N/A
Outpatient Surgery Physician/Surgical Services	No Limit	N/A	N/A	Surgeon 0% Cost Sharing
Outpatient Diagnostic and Routine Laboratory/Pathology/Routine Imaging (X-rays)/Imaging (CAT/PET/MRI)	No Limit	N/A	0% Cost Sharing	N/A
Radiation Therapy	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Home Health Care Services	Coverage is limited to 60 visits per calendar year.	N/A	0% Cost Sharing	0% Cost Sharing

Hemodialysis/Renal dialysis	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Out of Network Dialysis	Limit is 10 visits. Coverage for out of network provider on an in-network basis if member is traveling outside the service area.	N/A	0% Cost Sharing	0% Cost Sharing
Chemotherapy	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Preadmission Testing	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Autologous Blood Banking	Only in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury.	N/A	0% Cost Sharing	N/A
Outpatient Rehabilitation Services/Habilitation Services (PT, OT, ST)	ST: 60 vists per calendar year OT/PT: 120 visits per calendar year	N/A	0% Cost Sharing	0% Cost Sharing
Chiropractic Care	No Limit	N/A	N/A	0% Cost Sharing
Durable Medical Equipment	**Coverage for standard equipment only. DME defined as Equipment which is 1). Designed and intended for repeated use, 2), primarily and customarily used to serve a medical purpose, 3). Generally not useful to person in the absence of disease or injury, and 4) is appropriate for use in the home. Orthotics are excluded * See Model Language	N/A	N/A	0% coinsurance
Prosthetic Devices - External	2 external prosthetic device per lifetime *Coverage for external repairs or replacement in adults. - Coverage for wigs made from human hair if member is allergic to synthetic wig materials. To determine if this can be configured **Additional coverage for external device replacement for children for devices that have been outgrown - Coverage includes wigs for members suffering from severe hair loss due to injury or disease or treatment of a disease (e.g. chemotherapy)	N/A	N/A	0% coinsurance (for devices)
Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Infertility Treatment	Unlimited / Member must be between ages of 21 and 44 * Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy. Includes correctable medical conditions leading to infertility ** Advanced infertility is not covered	N/A	OP Fac cost sharing on surgeries done in AmSurg or OP Facility.	Surgeon 50 %Cost Sharing
Infertility Treatment	Provider visits and non surgical services under infertility treatment	N/A	0% Cost Sharing	0% Cost Sharing

Termination of Pregnancy	Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules	N/A	OP Amb Surgery Cost Sharing	Surgeon 0% Cost Sharing
Elective Termination of Pregnancy	One per calendar year Limit Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules ****(to discuss configuration of therapeutic vs elective; re: limits and differentiating via specific codes on claims - with Med Mgmt and Claims)	N/A	OP Amb Surgery Cost Sharing	Surgeon 0% Cost Sharing
Diabetic supplies	No Limit	N/A	N/A	0% Cost Sharing / 30 day supply
Diabetic drugs (including insulin)	No Limit	N/A	N/A	0% Cost Sharing / 30 day supply
Diabetic education and self-management	No Limit	N/A	N/A	0% Cost Sharing
Allergy testing and treatment; Allergy shots	No Limit	N/A	N/A	0% Cost Sharing
ABA treatment for Autism Spectrum Disorder	Actuarial equivalence to 680 hours per year annual ABA limit	N/A	N/A	0% Cost Sharing
Assistive Communication Devices for Autism Spectrum Disorder		N/A	N/A	0% Cost Sharing per device
Emergency Services		**IP Fac**	**OP Fac**	**Prof**
Emergency Room Services	No Limit. Copay waived if admitted as IP	N/A	0% Cost Sharing	0% Cost Sharing
Observation Stay	Copay waived if admitted as IP Note: If ER and Obs. Stay, only one copay.	N/A	0% Cost Sharing	N/A
Urgent Care Centers or Facilities	INN Coverage Only	N/A	0% Cost Sharing	Urgent Care 0% Cost sharing for "freestanding" Urgent Care (e.g., "doc in a box"). 0% cost sharing for Urgent Care physicians
Emergency Transportation/Ambulance	No Limit Covers Land, Air and Water	0% Cost Sharing		
Non Emergent Transportation/Ambulance	No Limit (Hospital to Facility transfer only) Land and Air only; Ambulette is excluded.	Covered in Full		

Hospitalization		IP Fac	OP Fac	Prof
Inpatient Hospital Services	No Limit*	0% Cost Sharing	N/A	N/A
Inpatient Physician and Surgical Services	No Limit	N/A	N/A	Surgeon cost sharing on surgeon claim. $0 cost sharing on all other IP professional svcs
Skilled Nursing Facility	Skilled Nursing limited to 200 days per calendar year*	0% Cost Sharing	N/A	$0 cost sharing on all SNF professional services
Delivery and all Inpatient Services for Maternity Care	No Limit (covers mother and newborn combined)*	0% Cost Sharing	N/A	Surgeon cost sharing on maternity delivery. Only one copay per pregnancy (e.g., covers delivery and post-natal svcs.)
Inpatient Rehabilitation Services	Inpatient rehabilitation therapy is covered for consecutive 60-day period, for physical, speech and occupational therapies when hospitalization would otherwise be necessary and the member must require skilled care on a daily basis, which is not primarily custodial and can only be provided on an inpatient basis. Admission must begin within six(6) months inpatient hospital stay or outpatient surgical procedure Copay not taken if member readmitted w/in 90 days for same or related condition. **Cardiac and Pulmonary Rehab is not covered.**	0% Cost Sharing	N/A	$0 cost sharing for any professional svcs associated with IP admission
Bariatric Surgery	No Limit*	0% Cost Sharing	0% Cost Sharing	Surgeon 0% Cost Sharing. $0 cost sharing on all other IP professional svcs
Mental Health and Substance Abuse Disorder Services		**IP Fac**	**OP Fac**	**Prof**
Mental/Behavioral Health Outpatient Services	No Limit Includes 20 OP visits for family counseling are covered.	N/A	0% Cost Sharing	0% Cost Sharing
Mental/Behavioral Health Inpatient Services	No Limit*	0% Cost Sharing	N/A	$0 cost sharing for any professional svcs associated with IP admission
Substance Abuse Disorder Outpatient Services	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Substance Abuse Disorder Inpatient Services	No Limit*	0% Cost Sharing	N/A	$0 cost sharing for any professional svcs associated with IP admission

Laboratory and Imaging Services		IP Fac	OP Fac	Prof
Diagnostic Test (X-Ray and Lab Work)	No Limit Note: only 1 copay applies and does not apply of claims for X-ray interpretation.	N/A	0% Cost Sharing	0% Cost Sharing
Imaging (CT/PET Scans, MRI)	No Limit Note: This does not apply to claims for interpretation of imaging	N/A	0% Cost Sharing	0% Cost Sharing
Preventive and Wellness Services		**IP Fac**	**OP Fac**	**Prof**
Preventive Care/Screening/Immunization	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. $0 cost sharing for ACA preventive svcs and other $0 cost sharing NYS mandates.	N/A	Covered in Full	Covered in Full
Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Pediatric Vision		**IP Fac**	**OP Fac**	**Prof**
Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	One exam per 12 month period. Up to age 19 end of month.	N/A	N/A	0% Cost Sharing
Prescription Lenses	Must provide coverage for eye exam, lenses and frames (once in any 12 month period) and contact lenses (only when deemed medically necessary)	N/A	N/A	0% coinsurance applies to combined cost of lenses and frames
Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation.	N/A	N/A	0% coinsurance applies to combined cost of lenses and frames
Contact Lenses	in lieu of frames	N/A	N/A	0% coinsurance
Other Services		**IP Fac**	**OP Fac**	**Prof**
Hospice Services (includes End of Life Care)	210 days/year; also includes 5 Bereavement Counseling sessions for members family either before or after the death of the member. For End of Life Care - Non-Par providers are covered. ** Refer to model language for rules	0% Cost Sharing	0% Cost Sharing	0% Cost Sharing
Family Planning - Contraceptive drugs and devices, tubal ligations	No Limit * Women's Wellness mandate	N/A	N/A	Covered in Full
Vasectomies-Office		N/A	N/A	0% Cost Sharing
Vasectomies-Outpatient/ Amb Surgery		N/A	0% Cost Sharing	Surgeon 0% Cost Sharing
Hearing Evaluations/testing	No Limit	N/A	N/A	0% Cost Sharing
Hearing Aids	Limited to a single purchase for one or both ears (including repair/replacement) every three years.	N/A	N/A	0% Cost Sharing

Outpatient Cardiac and Pulmonary Therapy	No limits in Model Language.	N/A	0% Cost Sharing	0% Cost Sharing
Second Opinion (surgical)	Second surgical opinion on the need for surgery.	N/A	N/A	0% Cost Sharing
Second Opinion (Specialist - cancer)	Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer. Copay applies to Par and Non Par	N/A	N/A	0% Cost Sharing
Transplants	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition * Solely for transplants for surgeries determined to be non-experimental and non-investigational.	0% Cost Sharing	N/A	Surgeon 0% Cost Sharing. $0 cost sharing on all other IP professional svcs
Oral Surgery	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition. * Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery *Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.	0% Cost Sharing	N/A	Surgeon 0% Cost Sharing. $0 cost sharing on all other IP professional svcs.
Oral Surgery	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition. * Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery *Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.	N/A	0% Cost Sharing	Surgeon 0% Cost Sharing

Oral Surgery	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition. * Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery *Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.	N/A	N/A	0% Cost Sharing
Infusion Therapy		N/A	N/A	0% Cost Sharing
Infusion Therapy	No limit	N/A	0% Cost Sharing	0% Cost Sharing
Anesthesia (all settings)	No limit	0% Cost Sharing	0% Cost Sharing	0% Cost Sharing
Prescription Drugs		**IP Fac**	**OP Fac**	**Prof**
Enteral Formulas	No Limit Note: Follows current practice for MM and Pharmacy	N/A	N/A	N/A
Retail: Tier 1/Generic: Tier 2/Formulary Brand Tier 3/Non-Formulary *Mail Order up to 90 day supply: 2.5x the 30 day supply cost sharing	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Specialty Drugs	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Off Label Cancer Drugs	30 day supply	N/A	N/A	N/A

(1) Pediatric Dental removed since standalone

GHI
Small Group Off Exchange Products
Underwriting Guidelines

Please refer to EH Small Group Underwriting Guidelines .pdf

GHI
Small Group Off Exchange Products
Commission Schedule and Fees

EmblemHealth Tri-State EPO HD6300 Commission	**0% of premium**
EmblemHealth Tri-State EPO HD6300 General Agent	**$0.00**

GHI
Small Group Off Exchange Products
Effective January 1, 2014-December 31, 2014

Contents **Page #**

SERFF Tracking #:	*GRPH-129013148*	***State Tracking #:***	*2013050229*	***Company Tracking #:***	*2013 0530 GHI SMALL GROUP OFF EXCHANGE*

State:	*New York*	***Filing Company:***	*Group Health Incorporated*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*GHI OFF Exchange Sm Grp*		
Project Name/Number:	*GHI Off Exchange Sm Grp/HCR-OX-100 et al*		

Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	See completed product checklist attached hereto.
Attachment(s):	HCR-OX-100 DFS Checklist FINAL w Act.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	Please find attached a pdf file containing readability certifications for the policy forms listed in the Form Schedule.
Attachment(s):	HCR-OX-100 et al readability.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variability

SERFF Tracking #:	*GRPH-129013148*	***State Tracking #:***	*2013050229*	***Company Tracking #:***	*2013 0530 GHI SMALL GROUP OFF EXCHANGE*

State:	*New York*	***Filing Company:***	*Group Health Incorporated*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*GHI OFF Exchange Sm Grp*		
Project Name/Number:	*GHI Off Exchange Sm Grp/HCR-OX-100 et al*		

Comments:	Forms HCR-OXR-A29, HCR-OXR-CC have no variable material. Form HCR-OX-100 utilizes model language almost exclusively. Any variable material is largely self-explanatory and is limited to GHI addresses, telephone numbers and contact points that may change over time, model plan year definition options, model dependent coverage limiting provisions and to the following substantive provisions: 1. Allowed Charge for Non-Participating Providers: This non-model lanague provides an option for use of cap of 500% of Medicare as a cap to payment of facility charges, and it also provides an option for use of either the 90th percentile of FairHealth, or an alternative for use of Medicare-based reimbursement. GHI intends to utilize (and is filing rates only for use of) the 90th percentil of FairHealth for non-facility services. As to the latter, GHI will submit a rate filing in the future should it opt to utilize the Medicare based reimbursement option for non-facility providers. 2. Religious Employer Provisions: Consistent with the DFS model language, provisions that may be offered by rider to religious employers appear in brackets and will be deleted in the event the plan is issued to a qualified religious employer. 3. Other Covered Services: There are a number of variable provisions in this section, which may or may not be included depending upon the ERISA status of the group policyholder and with respect to the discount programs, the continued participation of the vendor in GHI's discount program(s). Group Contract Form HCR-OX-GC1 and application form 155-23-EMBLEMAPP-OX14 have minimal variable material which will either be included or excluded as applicable and/or self-explanatory.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Act Memo GHI SG Off Exchange 2014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations
Comments:	Actuarial Value Calculation for Small Group Bronze Plan
Attachment(s):	Appendix C.pdf
Item Status:	

SERFF Tracking #:	*GRPH-129013148*	***State Tracking #:***	*2013050229*	***Company Tracking #:***	*2013 0530 GHI SMALL GROUP OFF EXCHANGE*

State:	*New York*	***Filing Company:***	*Group Health Incorporated*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*GHI OFF Exchange Sm Grp*		
Project Name/Number:	*GHI Off Exchange Sm Grp/HCR-OX-100 et al*		

Attachment(s):	GHI SG Exhibit 1 Redacted.pdf Act Memo GHI SG Off Exchange 2014 Redacted.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	GHI SG URR.xlsm GHI SG URR.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum Attachments
Comments:	Find attached the appendices to the Act Memo
Attachment(s):	Act Memo Appendices SG.pdf
Item Status:	
Status Date:	

Review Standards for

Major Medical and Other Similar-Type Comprehensive Health Insurance for Small Groups
As of 4/22/13

Instructions for SERFF Checklist:

A. For **ALL** filings, the "General Requirements for All Filings" section must be completed:

B. For a **FORM** filing, completion of additional sections may be required as follows, depending on the type of form being submitted:

- Policy or Contract – Also complete all sections
- Rider or endorsement – Also complete all items relevant to the form being submitted in all sections.

C. For filing of initial rates, complete the section entitled "Actuarial Section for New Product Rate Filings Only" in addition to completion of the applicable form sections identified above. For filing of rate changes to existing products (increases, decreases, or change in rate calculation rules or procedures), complete the "Actuarial Section for Existing Product Rate Filings Only" section. For filing of any other changes to rate or underwriting manuals (e.g., changes in commissions or underwriting), complete the "Actuarial Section for Existing Product Rate Filings Only" section.

D. For each item, enter in the last column the form number(s), page number(s) and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing. All items with shaded boxes must be answered.

E. Do not make any changes or revisions to this checklist.

F. **Checklist Updates:** Any items on the checklist that have been updated since the last posting are shaded.

G. **Instructions for Citations:** All citations to Insurance regulations link to the Department of State's website and an unofficial copy of the NYCRR. Please select title 11 for Insurance regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, please select the link labeled "ISC".

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Major Medical and Other Similar-Type Comprehensive Health Insurance for Small Groups

LINE OF BUSINESS:	**Group Major Medical or Similar-Type Comprehensive Health Insurance**	LINE(S) OF INSURANCE	CODES
CODE:	H15G	Health – Hospital/Surgical/Medical Expense	H15G.001 H15G.002 H15G.003
	H16G	Health – Major Medical	H16G.001A H16G.001B H16G.001C H16G.002A H16G.002C H16G.003A H16G.003D
	H16G.003G		

IF CHECKLIST IS NOT APPLICABLE, OR IF THE SUBMISSION CONTAINS INSERT PAGES, RIDERS OR ENDORSEMENTS AND THE POLICY OR CONTRACT IN ITS ENTIRETY DOES NOT COMPLY WITH ALL STATUTORY AND REGULATORY PROVISIONS STATED BELOW, PLEASE EXPLAIN:

REVIEW REQUIREMENT	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
GENERAL REQUIREMENTS FOR ALL FILINGS	*Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department of Financial Services Circular Letters and OGC opinions*	*Note: This checklist is intended to provide guidance in the preparation of policy or contract forms for submission and is not intended as a substitute for statute or regulation.*	Form/Page/Para Reference
Complete Policy or Contract Submission or Pages/Rider/Endorsement		This submission contains a complete policy or contract form. Yes ☒ No ☐ If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☒ No ☐	

Major Medical and Other Similar-Type Comprehensive Health Insurance for Small Groups

		(If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on , submission number .	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF.	Note that the form(s) will be formally formatted, paginated and printed for issuance upon approval.
Flesch Score	§3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	See readability certification.
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF Filing Description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form is a policy or contract, the letter must indicate that the policy or contract is submitted pursuant to 11 NYCRR 52.7. §52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f) • If the form is other than a policyor contract form, the letter must identify the form number and	See General Description of SERFF submission.

		approval date of the policy or contract with which it will be used. If the form is for general use, the Department may accept a description of the type of policy or contract with which it may be used in lieu of the form number and approval date. §52.33(g) • If the form is a policy or contract, the letter must identify the form numbers and dates of approval of any applications previously approved to be used with the policy or contract unless the application is required to be attached to the policy or contract upon submission. §52.33(h) • If the policy or contract is designed to be used with insert pages, the letter must contain a statement of the insert page forms which must always be included in the policy or contract and a list of all optional pages, together with an explanation of their use. § 52.33(i) • *Note: Submission letters and or the SERFF filing description should advise as to whether the policy or contract is intended for internet sales and should describe any proposed electronic procedures and/or the proposed use of electronic signatures associated with the sale of the policy or contract.*	
Group Status and Recognition	§ 4235(c)(1)(A) §3201(b)(1) 11 NYCRR 59	The SERFF filing description or submission letter should include a statement that policy or contract forms will be sold to a group specified in Insurance Law §4235(c)(1). However, a more detailed statement must be included where discretionary group status is sought under Insurance Law §4235(c)(1)(M). The size of the group should be indicated as small. Please indicate whether the submission is for general use or is submitted on a one case basis. If the submission is for use on a one case basis, the group must be identified along with the subpart of Insurance Law §4235(c)(1) in which the group fits and a confirmation that the group meets all of the requirements of the identified subpart. Requests for discretionary group recognition, pursuant to Insurance Law §4235(c)(1)(M), must be accompanied by written documentation that demonstrates that the proposed group meets each and every element stated in the named statute. The documentation must also make clear that the request for discretionary group recognition is not a subterfuge, evasion technique, or a marketing tool to avoid compliance with other statutory or regulatory requirements and recognized marketing mechanisms. This provision is not intended to allow approval of groups recognized in the various subparagraphs of §4235(c)(1), but for which the proposed discretionary group does not meet one or more of the requisites specifically required or proscribed by §4235. The request for allowance of a discretionary group must be granted before it may be used. Pursuant to §3201(b)(1) and Insurance Regulation 123, an accident and health certificate is deemed delivered in New York and subject to review and approval regardless of the actual place of delivery, if the policy is issued to certain groups. In these cases, the group certificate is reviewed for compliance with New York Law. The group policy/contract that is delivered out-of-state is not reviewed.	See Group Contract form HCR-OX-GC1, Article II.
Prefiled Group Coverage	11 NYCRR 52.32	A copy of the letter of confirmation sent to the group by the insurer must be submitted to the Department within 30 days after the date the insurer agrees to provide insurance and must include the following: • The effective date of coverage. § 52.32(a)(1) • The nature and extent of the benefits or change in benefits as then known. § 52.32(a)(2) • That the contractual forms may be executed and issued for delivery only after filing with or	Not applicable.

		approval by the Department. §52.32(a)(3) • That if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval. §52.32(a)(4) *Note: At the time the insurer agrees to provide insurance, it cannot have been reasonably possible to obtain approval prior to the effective date of coverage because the group requested the insurer provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the insurer agrees to provide insurance. § 52.32(c). Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.*	
Statement of ERISA rights Is the insurer providing document as the plan administrator or for the plan administrator? Yes ☐ No ☒	29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)	Plan administrators of an employee benefit plan are required to furnish a copy of a Statement of ERISA rights as provided for in 29 CFR § 2520.102-3(t). If the insurer is providing this document as the plan administrator, or for the plan administrator, please indicate in the adjacent box.	Not applicable.
APPLICATION FORMS Model Application Used? Yes ☐ No ☒	Model Language		Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	See form 155-23-EMBLEMAPP-OX14
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	See form 155-23-EMBLEMAPP-
Prohibited Questions and Provisions	§3221(q)(1) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy or contract to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy or contract void. An agreement that acceptance of any policy or contract issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	See form 155-23-EMBLEMAPP-OX14
Verification of Compliance with Pediatric Essential Dental Health Benefit.	45 CFR § 156.150	In order to verify whether an individual has obtained stand-alone dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange, insurers should use the following language on their application/enrollment form:	

		A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? Yes No B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____ If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.	See form 155-23-EMBLEMAPP-OX14. See also checklist pp. 33 and General Description.
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes ☒ No ☐	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	See HCR-OX-100 , cover page.
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	See HCR-OX-100 , cover
Table of Contents Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	A table of contents is required.	See HCR-OX-100, Table of Contents.
DEFINITIONS Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	*For a complete listing of the definitions click on the adjacent Model Language link*	Form/Page/Para Reference
Services Performed at Comprehensive Care Center for Eating Disorders	§3221(k)(14) §4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Form utilizes DFS model langauge almost exclusively.
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	See HCR-OX-100 , Section II.
Designation of Primary Care	§3217-e	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract	

Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☒ No ☐	§4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	See HCR-OX-100 , Section II.
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☒ No ☐	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer.	See HCR-OX-100 , Section II.
Preauthorization			
Preauthorization Requirements Model Language Used? Yes ☒ No ☐	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b) Model Language	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or $500.00, whichever is less, is permissible.	See HCR-OX-100, Section XIV.
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes ☒ No ☐	§3217-a(a)(1) §4324(a)(1) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	See HCR-OX-100 , Section II
Contact Information Model Language Used? Yes ☒ No ☐	§3217-a(a)(16) §4324(a)(16) PHL§4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	See HCR-OX-100 , Section II
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the	See HCR-OX-100 , Section III

		insured can obtain such referral.	
Specialty Care Provider as PCP Model Language Used? Yes ☒ No ☐	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	PCP designation not required. See HCR-OX-100 , Section III
Standing Referrals Model Language Used? Yes ☒ No ☐	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	PCP designation not required. See HCR-OX-100 , Section III
Specialty Care Center Model Language Used? Yes ☒ No ☐	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	PCP designation not required. See HCR-OX-100 , Section III
Transitional Care When A Provider Leaves the Network Model Language Used? Yes ☒ No ☐	§4804(e) §3217-d(c) §4306-C(c) PHL §4403(6)(e) Model Language	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	See HCR-OX-100 , Section III
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ☒ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the	See HCR-OX-100 , Section III

		non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes ☒ No ☐	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	See HCR-OX-100, Section III.
Reimbursement of Providers Model Language Used? Yes ☐ No ☒	§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	See HCR-OX-100, Section III. Non-model language used t
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes ☒ No ☐	§3217-a(a)(6) §4324(a)(6) PHL §4408(1)(f) Model Language	This policy or contract form includes a description of the insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	See HCR-OX-100, cover page and Section III. Plan does not cover out of network services
ELIGIBILITY Model Language Used? Yes ☒ No ☐	Model Language		Form/Page/Para Reference
Spouse	§4235(f)(1)(A) §4305(c)(1) Circular Letter No. 27 (2008) Model Language	If dependent coverage is selected by the group, this policy or contract form must provide coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex partners legally performed in this state and in other jurisdictions.	See HCR-OX-100, Section V.
Dependents	§4235(f)(1)(A)(i) §4305(c)(1) §3221(a)(7) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	If dependent coverage is selected by the group, this policy or contract form provides coverage of children until age 26. *Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.*	See HCR-OX-100, Section V.

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Extended Dependent Coverage Model Language Used? Yes ☒ No ☐	§4235(f)(1)(B) §4305(c)(1) Model Language	If dependent coverage is selected by the group, this policy or contract must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in 4235(f).	See HCR-OX-100, Section V.
Unmarried Students on Medical Leave of Absence	§3237 §4306-a 42 USC §300gg-7	If this policy or contract form provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness or injury for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	See HCR-OX-100, Section V.
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4305(c)(1) Model Language	If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.*	See HCR-OX-100, Section V.
Newborn Infants	§4235(f)(2) §4305(c)(1) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of individual or two-person coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.*	See HCR-OX-100, Section V.
Adopted Children and Step-Children	11NYCRR52.18(e)(2);(3) §4305(c)(1)	If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage	See HCR-OX-100, Section V.

		on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners	§4235(f)(1)(A) §4305(c)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case.	See HCR-OX-100, Section V.
New Family Members Model Language Used? Yes ☒ No ☐	45 C.F.R. § 155.420 Model Language	The policy or contract form describes the requirements to add new family members to the policy or contract.	See HCR-OX-100, Section V.
New Employees	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	See HCR-OX-100
Enrollment Periods	http://government.westlaw.com/linkedslice/default.asp?SP=nycrr-100011NYCRR52.70(e)(3) 45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	See HCR-OX-100, Section V.
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS		**Except where noted below, the following benefits must be included in the policy or contract forms.** Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including higher visit	Form/Page/Para Reference

		limitations; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance, as well as DFS review. The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☒ No ☐	§3221(l)(8) §3221(k)(18) §4303(j) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Federal Mandated Preventive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Cervical Cytology Screening Model Language Used? Yes ☒ No ☐	§3 221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	See HCR-OX-100, Section VI.
Mammography Screening	§ 3221(l)(11) § 4303(p)	This policy or contract form includes the following coverage for mammography screening for occult breast cancer:	

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Model Language Used? Yes ☒ No ☐	42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	• Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	See HCR-OX-100, Section VI.
Family Planning & Reproductive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines	This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☒ No ☐	§ 3221(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals: • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis. Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance	See HCR-OX-100, Section VI.
Prostate Cancer Screening Model Language Used? Yes ☒ No ☐	§ 3221(l)(11-a) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and	See HCR-OX-100, Section VI.

		• An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§ 3221(l)(15) § 4303(aa) Model Language	**Emergency Medical and Ambulance Services:** This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person's bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person. An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization. **Non-Emergency Ambulance Services:** This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following: • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	See HCR-OX-100, Section VI.
Emergency Services Model Language Used? Yes ☒ No ☐	§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage	See HCR-OX-100, Section VI.

	(2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language	that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).*	
Urgent Care Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	See HCR-OX-100, Section VI.
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging	45 CFR § 156.100	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT	

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Model Language Used? Yes ☒ No ☐	Model Language	scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Allergy Testing and Treatment Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Ambulatory Surgery Center Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Chemotherapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Chiropractic Care Model Language Used? Yes ☒ No ☐	§3221(k)(11) §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	See HCR-OX-100, Section VI.
Dialysis Coverage	§3221(k)(16) §4303(gg)	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis	

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Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.	See HCR-OX-100, Section VI.
Outpatient Habilitative Services Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI. Note that the visit limits are 60 for speech therapy and 120 for physical/ occupational therapy, per calendar year combined with outpatient rehabilitative.
Benefit explanation:			

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Home Health Services Model Language Used? Yes ☒ No ☐	§3221(k)(1) §4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.	See HCR-OX-100, Section VI. Note that the number of visits is increased to 60.
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. *Note: Plans must include the one procedure limit and may provide coverage that is more favorable.*	See HCR-OX-100, Section VI.
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes ☒ No ☐	§3221(k)(6) 4303(s) 11 NYCRR 52.18(a)(10) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs;	See HCR-OX-100, Section VI.

		cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	See HCR-OX-100, Section VI.
Infusion Therapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Office Visits Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Outpatient Hospital Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Preadmission Testing Model Language Used? Yes ☒ No ☐	§3221(k)(2) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Outpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has	See HCR-OX-100, Section VI. Note that the visit limits are 60 for speech therapy and 120 for physical/ occupational therapy, per calendar year

Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.		undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Plans may: increase the number of covered visits; cover 60 or more visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.*	
Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ☒ No ☐	§3221(k)(9) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	See HCR-OX-100, Section VI.
Second Surgical Opinion Model Language Used? Yes ☒ No ☐	§3221(k)(3) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Mandatory Second Surgical Opinion	§3221(k)(3) 4303(b)	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979).	

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Model Language Used? Yes ☒ No ☐	Circular Letter No. 29 (1979) Model Language	Such coverage may not be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Second Opinion in Other Cases Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Surgical Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.6 Model Language	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Oral Surgery Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Mastectomy Care Model Language Used? Yes ☒ No ☐	§3221(k)(8) §4303(y) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	See HCR-OX-100, Section VI.
Post Mastectomy Reconstruction	§3221(k)(10) §4303(x) Women's Health and	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a	See HCR-OX-100, Section VI.

Model Language Used? Yes ☒ No ☐	Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	
Transplants Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Autism Spectrum Disorder Model Language Used? Yes ☒ No ☐	§3221(l)(17) §4303(ee) Model Language 11 NYCRR 440	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy or contract provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. This policy or contract form shall include a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy or contract form shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year.	See HCR-OX-100, Section VI.

		The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§3221(k)(7) §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3221(k)(7) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. *Note: Plans may apply either a medical or a prescription benefit depending upon whichever will provide a more generous benefit.* *Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician "or other licensed health care provider legally authorized to prescribe under title eight of the education law...," the policy or contract form may not limit coverage to care prescribed by a physician.*	See HCR-OX-100, Section VI.
Durable Medical Equipment and Braces Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Hearing Aids Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for plans but the limit may be removed or modified so that coverage is more favorable.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for	See HCR-OX-100, Section VI.

		malfunctions. *{Drafting Note: The limit on hearing aids is required for plans but this limit may be removed or modified so that coverage is more favorable.}* Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes ☒ No ☐	§3221(l)(10) §4303(o) 45 CFR § 156.100 Model Language	This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits. *Note: A plan must cover 210 days of hospice care; however plans can cover more than 210 days.*	See HCR-OX-100, Section VI. For adults, 2 prosthetic devices covered per lifetime.
Prosthetics Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	External Prosthetic Devices: This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for plans, but the limit may be removed or modified so that coverage is more favorable.* Internal Prosthetic Devices: This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.

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Hospital Services Model Language Used? Yes ☒ No ☐	11NYCRR52.5 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Maternity Care Model Language Used? Yes ☒ No ☐	§3221(k)(5) 4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3221(k)(1), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.	See HCR-OX-100, Section VI.

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		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Inpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. *Note: Plans must cover 60 days; however plans may exceed the required 60 day, and also may remove the "per condition" and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	See HCR-OX-100, Section VI. Note that per lifetime cap is replaced with a per calendar year cap.
Benefit explanation:			
Skilled Nursing Facility Model Language Used? Yes ☒ No ☐	§3221(l)(2) §4303(d) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: Plans must cover 200 days, but may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
End of Life Care Model Language Used?	§4805 PHL §4406-e 45 CFR § 156.100	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	See HCR-OX-100, Section VI.

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Yes ☐ No ☐	Model Language		
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	§3221(l)(5) §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, small group health policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
Outpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	3221(l)(5) §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the*	See HCR-OX-100, Section VI.

		treatment of mental health conditions and substance use disorder consistent with the federal law.	
Inpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3221(l)(6) §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	See HCR-OX-100, Section VI.
Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3221(l)(7) §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.	See HCR-OX-100, Section VI.

		Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.* *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the same number of prescription drugs in each category and class as the benchmark plan. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
Enteral Formulas Model Language Used? Yes ☒ No ☐	§3221(k)(11) §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited	See HCR-OX-100, Section VI.

		diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Off-Label Cancer Drug Usage Model Language Used? Yes ☒ No ☐	§3221(l)(12) §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	See HCR-OX-100, Section VI.
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ☒ No ☐	§4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	See HCR-OX-100, Section VI.
Prohibition for Tier IV Drugs	§3221(a)(16) §4303(gg) PHL §4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	See HCR-OX-100, Section VI.
Eye Drops Model Language Used? Yes ☒ No ☐	§3221(k)(17) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	See HCR-OX-100, Section VI.
Orally Administered Anticancer Medications Model Language Used? Yes ☒ No ☐	§3221(l)(12-a) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	See HCR-OX-100, Section VI.
Mail Order Drugs for Policies With a Provider Network Model Language Used? Yes ☒ No ☐	§3221(l)(18) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	See HCR-OX-100, Section VI.
Contraceptive Drugs and Devices Model Language Used?	§3221(l)(16) §4303(cc) 42 USC §300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the Federal Food and Drug Administration. For groups that meet the definition of a religious employer in §§3221(l)(16)(A); 4303(cc)(1)(A), the subscriber will have the option to purchase the stand alone contraceptive coverage rider. Contraceptive coverage	See HCR-OX-100, Section VI.

Yes ☒ No ☐		must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law...," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ *Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.* Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.	45 CFR § 156.100 §3239 Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of $200.00 for the subscriber and $100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. *Note: Plans may offer more comprehensive coverage or may substitute this benefit.*	See HCR-OX-100, Section VI.
Benefit explanation:			
Other Wellness Benefits	45 CFR § 156.100 §3239	Additional Wellness Benefits may be covered. All additional wellness benefits must comply with § 3239 of Insurance Law.	Not applicable. But see HCR-OX-100, Section
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care	45 CFR § 156.100	This policy or contract form provides coverage for pediatric vision care including: emergency,	

Model Language Used? Yes ☒ No ☐	Model Language	preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	See HCR-OX-100, Section VI.
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☐ No ☒ Is dental coverage being provided by the insurer in this filing? Yes ☐ No ☒ If No, please provide information in the explanation box below as to how the insurer is meeting the requirement to offer the pediatric essential health benefit.	45 CFR § 156.100 45 CFR § 156.150 Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Insurers are required to offer the pediatric dental essential health benefit as either an embedded benefit (coverage provided by the insurer) or bundled benefit (coverage provided through an arrangement with another insurer).* *Embedded pediatric dental benefits must comply with all of the market reform and rating rules such guaranteed availability, rating tiers, rating regions, etc. For rating purposes, the pediatric dental benefit would be included in the insurer's single risk pool, medical loss ratio calculations and actuarial value calculations. Expenses related to an embedded pediatric dental benefit must also be included as part of the calculation of deductibles and out of pocket expense maximums.* *If the insurer offers a bundled stand-alone pediatric dental benefit, the following conditions must all be met:* *• The bundled dental benefit is identical to a stand-alone dental plan offered by the same dental carrier that is certified by the Exchange but offered outside the Exchange, including at the same premiums;* *• The policyholder or contractholder is informed that the dental benefit is being offered by a separate insurer, even if only one issuer collects the premiums;* *• The policyholder or contractholder is clearly informed of the medical plan design and the dental plan design and that the two plan designs have different deductibles, cost sharing and OOP maximums;* *• The policyholder or contractholder is clearly informed that they can purchase any stand-alone dental plan, other than the bundled dental plan, that has been certified by the Exchange but offered outside the Exchange.* *• The pediatric dental benefit meets the 70% or 85% actuarial value and $700 OOP maximum for one covered child (or $1,400 if more than one child in the family is covered);*	

		• The stand alone dental plan complies with all ACA provisions and CMS regulations pertaining to stand alone dental plans; *• Insurers should specifically describe the legal and business arrangement between the medical issuer and the dental issuer when submitting the forms and rates to DFS, and each insurer must separately submit its own forms and rates for approval.* *If the insurer is reasonably assured that an individual has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange the insurer does not need to provide the dental benefit when coverage is issued. Insurers may include a question in their application/enrollment form in order to verify whether an insured has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange*	

Explanation:
As indicated in the General Description and in the application form for this small group product, if the applicant does not already have pediatric dental care coverage, GHI intends to "bundle" the coverage in form HCR-OX-100 with a stand-alone pediatric dental plan underwritten by another carrier. Please refer to the General Description for information about the legal and business relationship between GHI and the dental carrier.

ADDITIONAL BENEFITS			
Family Vision Model Language Used? Yes ☒ No ☐	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	See HCR-OX-100, Section VI.
Orthotics Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	See HCR-OX-100, Section VI.
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	http://public.leginfo.state.ny.us/menugetf.cgi?COMMONQUERY=LAWS11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	See HCR-OX-100, Section VI.

Explanation:

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Acupuncture		This policy or contract form provides coverage for acupuncture.	
MAKE AVAILABLE BENEFITS			
Care in a Nursing Home or Skilled Nursing Facility	§ 3221(l)(2) § 4303(d)	This policy or contract must make available coverage for care in a nursing home, as defined by Public Health Law §2801, or a skilled nursing facility as defined in 42 USC §§1395, when such services are preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.	Not applicable. SNF care is an essential health benefit in NYS.
Licensed Clinical Social Worker	§ 3221(l)(4) § 4303(i)	If this policyor contract provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments by physicians, psychiatrists or psychologists, the policy or contract must make available and if requested by the policyholder, provide the same coverage to insureds for the such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to Article 154 of the Education Law (Education Law § 7700 et seq.).	Not applicable. Plan covers essential health benefits.
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	See HCR-OX-100, Section VII.
Convalescent and Custodial Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.	See HCR-OX-100, Section VII.
Cosmetic Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	See HCR-OX-100, Section VII.
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	See HCR-OX-100, Section VII.
Dental Services	11NYCRR52.16(c)(9	This policy or contract form excludes coverage for dental services except for: care or treatment due to	

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Model Language Used? Yes ☒ No ☐	) Model Language	accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	See HCR-OX-100, Section VII.
Experimental or Investigational Treatment. Model Language Used? Yes ☒ No ☐	§3221(k)(12) § 4303(z) Article 49 Model Language	This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.	See HCR-OX-100, Section VII.
Felony Participation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	See HCR-OX-100, Section VII.
Foot Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(6) .Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	See HCR-OX-100, Section VII.
Government Facility Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	See HCR-OX-100, Section VII.
Medically Necessary Model Language Used? Yes ☒ No ☐	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent certified by the State.	See HCR-OX-100, Section VII.
Medicare or Other Governmental Program Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	See HCR-OX-100, Section VII.
Military Service Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	See HCR-OX-100, Section VII.
No-Fault Automobile Insurance Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	See HCR-OX-100, Section VII.

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Services Separately Billed by Hospital Employees Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	See HCR-OX-100, Section VII.
Services Provided by a Family Member Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	See HCR-OX-100, Section VII.
Services With No Charge Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	See HCR-OX-100, Section VII.
Services not Listed Model Language Used? Yes ☒ No ☐	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy or contract form as being covered.	See HCR-OX-100, Section VII.
Vision Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	See HCR-OX-100, Section VII.
Workers' Compensation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	See HCR-OX-100, Section VII.
War Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	See HCR-OX-100, Section VII.
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim Model Language Used? Yes ☒ No ☐	§3221(a)(8) Model Language	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	See HCR-OX-100, Section VIII.
Submission of Claim Model Language Used? Yes ☒ No ☐	§3221(a)(9) §4305(m) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	See HCR-OX-100, Section VIII.

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GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(p) PHL § 4408-a 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any.	See HCR-OX-100, Section IX.
Utilization Review Policies and Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	This policy or contract form includes a description of the utilization review policies and procedures, including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; • the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	See HCR-OX-100, Section IX
External Appeal Procedures Model Language Used? Yes ☒ No ☐	Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	This policy or contract form includes a description of the external appeal procedures, including: • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal.	See HCR-OX-100, Section IX

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COORDINATION OF BENEFITS Model Language Used? Yes ☒ No ☐	11 NYCRR 52.23 Model Language	If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	Form/Page/Para Reference
TERMINATION OF COVERAGE Model Language Used? Yes ☒ No ☐	Model Language	*The following are the only termination provisions permissible under the Insurance Law.*	Form/Page/Para Reference
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	See HCR-OX-100, Section
Termination for Failure to Pay Premiums	§3221(p)(2)(A) §4305(j)(2)(A)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments.	See HCR-OX-100, Section XI
Termination for Fraud	§3221(p)(2)(B) §4305(j)(2)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or a subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	See HCR-OX-100, Section XI
Termination for Failure to Comply With a Material Plan Provision	§3221(p)(2)(C) §4305(j)(2)(C)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to terminate coverage if the group has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.	See HCR-OX-100, Section XI
Discontinuation of a Class of Coverage	§3221(p)(2)(D); §3221(p)(3)(A) §4305(j)(2)(D) §4305(j)(3)(A)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each group, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer groups the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those groups or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	See HCR-OX-100, Section XI
Discontinuation of all Policies/Contracts in the Small Market	§3221(p)(2)(D); §3221(p)(3)(B) §4305(j)(2)(D) §4305(j)(3)(B)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the small group market upon written notice to the superintendent and to each group, participant, and beneficiary at least 180 days prior to the date of discontinuance.	See HCR-OX-100, Section XI
Termination for Failure to Meet Requirements of Group	§3221(p)(2)(E); §4235(c)(1) §4305(j)(2)(E)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group ceases to meet the requirements of a group under §4235. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.	See HCR-OX-100, Section XI
Termination if there are No Longer Insureds in the Insurer's Service Area	§3221(p)(2)(F) §4305(j)(2)(F)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	See HCR-OX-100, Section XI
Termination for Spouses in cases of divorce		This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	See HCR-OX-100, Section

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Termination upon death of Subscriber		This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	See HCR-OX-100, Section XI
Termination by Subscriber		This policy or contract form provides that termination will occur at the end of the month during which the subscriber provides written notice requesting termination or on such later date requested for such termination by the notice.	See HCR-OX-100, Section XI
Rescission Model Language Used? Yes ☒ No ☐	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	See HCR-OX-100, Section XI
Renewal	§3221(p) §3221(a)(5) 4305(j) 11 NYCRR 52.18(c)	This policy or contract provides that except as specified in §3221(p), or §4305(j) the insurer must renew or continue in force such coverage at the option of the group. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	See HCR-OX-100, Section XI
Premiums	§3221(a)(4)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	See HCR-OX-100, Section
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes ☒ No ☐	11 NYCRR 52.18(b)(4); (5); and (6) Model Language	This policy or contract form provides that when coverage under this policy or contract form ends, benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability. If the covered persons' coverage terminates by reason of the termination of active employment, an extended benefit will be proved during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.	See HCR-OX-100, Section XII
Continuation Coverage Model Language Used? Yes ☒ No ☐	§3221(e)(11) §3221(m) §4305(e) COBRA, Title X of Public Law 99-272 Model Language	This policy or contract form contains a provision regarding continuation coverage. §§3221(m) and 4305(e) provide continuation coverage in circumstances when federal COBRA requirements do not apply, including for groups under 20 and upon application of the employee or member to continue hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents. An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by the group. The Insurance Law permits the group to charge an additional 2% administrative fee for continued coverage.	See HCR-OX-100, Section XII

		The continuation benefits terminate: • 36 months after the date the employee or member's benefits would otherwise have terminated because of termination of employment or membership. • In the case of an eligible dependent, 36 months after the date such person's benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy or contract. • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage. • The end of the period for which premiums were made if the employee or member fails to make timely payment.	
Young Adult Option Model Language Used? Yes ☒ No ☐	§3221(r) §4305(l) Model Language	This policy or contract form provides notice of a young adult's right, through the age of 29 (up to age 30), to independently purchase coverage through a parent group member's policy or contract, regardless of whether the parent's coverage includes coverage for dependents, as described in 3221(r), and/or 4305(l). If a young adult or the young adult's parent elects this coverage, the young adult is issued a separate individual policy or contract. The insurer must comply with the notice requirements to each employee or member as set forth in 3221(r), and/or 4305(l).	See HCR-OX-100, Section XII
Suspension of Coverage Model Language Used? Yes ☒ No ☐	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.	See HCR-OX-100, Section XII
Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard	§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) Model Language	If the group does not choose to voluntarily maintain coverage for any employee or member of when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.	See HCR-OX-100, Section XII

Model Language Used? Yes ☒ No ☐			
Conversion - Right to a New Contract After Termination Model Language Used? Yes ☒ No ☐	§3221(e) §4303(d)	This policy or contract form provides that if the employee under the group contract ceases to be covered because of termination of coverage because of: (1) termination for any reason of his employment, or (2) termination for any reason whatsoever of the group policy or contract itself, unless the group policy or contract holder has replaced the group policy or contract with similar and continuous coverage for the same group, such employee shall be entitled to a new policy or contract as a direct pay member, covering such member and his eligible dependents. Conversion must also be made available, upon the death of the employee, to the surviving spouse and dependents, and the former spouse of the employee upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract or whose young adult coverage terminates. The policy or contract form provides that the employee or his eligible dependents must request conversion within sixty days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. The employee or his eligible dependents must also pay the first premium of the new contract at the time they apply for coverage. Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.	See HCR-OX-100, Section XII
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes ☒ No ☐	§3221(a)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	See HCR-OX-100, Section XIII.
Changes Model Language Used? Yes ☒ No ☐	§3221(a)(2) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the group and insurer.	See HCR-OX-100, Section XIII.
Action in Law or Equity Model Language Used? Yes ☒ No ☐	§3221(a)(14) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy or contract.	See HCR-OX-100, Section XIII.
Subrogation Model Language Used? Yes ☒ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	See HCR-OX-100, Section XIII.

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	Model Language		
Unilateral Modification Model Language Used? Yes ☒ No ☐	11NYCRR52.18(a)(8) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the group. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the group to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such group no less than 14 days prior to the date by which the group is required to provide notice to terminate coverage.	See HCR-OX-100, Section XIII.
Non-English Speaking Insureds Model Language Used? Yes ☒ No ☐	§3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	See HCR-OX-100, Section XIII.
SCHEDULE OF BENEFITS Model Language Used? Yes ☒ No ☐	Model Language	This policy or contract must contain a Schedule of Benefits. All services subject to preauthorization must be clearly indicated in the Schedule of Benefits.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	See HCR-OX-100, Section XIV.
Limitations on Annual Dollar Limits Model Language Used? Yes ☒ No ☐	§3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	See HCR-OX-100, Section XIV.
Insured's Financial Responsibility for Payment	§3217-a(a)(5) §4324(a)(5) PHL §4408(1)(e)	This policy or contract form includes a description of the insured's financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	See HCR-OX-100, Section XIV.
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☐ No ☒ If Out-of-Network coverage is offered please answer the following:	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not permit more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	Not applicable.

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Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☐			
Extended Dependent Coverage Model Language Used? Yes ☒ No ☐	§4235(f)(1)(B) §4305(c)(1) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in §§ 4235(f) or 4305(c)(1).	See rider HCR-OXR-A29.
Contraceptive Drugs and Devices and Family Planning Services	§3221(l)(16)	This policy or contract form includes a rider for situations when a Group has elected not to purchase coverage for contraceptive drugs or devices pursuant to the religious employer exemption pursuant to §§3221(l)(16)(A); 4303(cc)(1)(A). In accordance with law, if elected by an insured, this Rider amends the policy or contract and provides coverage for contraceptive drugs or devices or generic equivalents approved as substitutes by the federal food and drug administration and provides coverage for family planning services.	See rider HCR-OXR-CC
PROVIDER NETWORKS Has network been submitted to and/or approved by the Department of Health or the Exchange? Yes ☐ No ☒ If yes, please indicate the name of the network, the network ID number, and the dates that the network was submitted to and/or approved by the Department of Health or the Exchange. Network Name: Network ID #: Date Submitted: Date Approved:	§3201(c)	If the insurance (other than HMO) policy or contract will be used in conjunction with a provider network, please identify in the adjacent box whether the insurer is using the same network that was submitted to and/or approved by the Department of Health and/or the Exchange. Please indicate the network name and network ID number and include the date that the network was submitted to and/or approved by the Department of Health and/or the Exchange. If the network differs in any respect from that which was submitted to and/or approved by the Department of Health and/or the Exchange, please provide details on how the network differs in the Supporting Documentation Tab in SERFF. This includes, but is not limited to, detailing the providers and specialty types in each county that differ from the network that was submitted to and/or approved by the Department of Health and/or the Exchange . In addition, the following items or information must be submitted as part of this filing: • Participating provider directory; • Whether the provider network is capitated; • Provider selection criteria; • Quality assurance procedures; • Breakdown of geographic service area by county; • The underlying assumptions for the network regarding ratios of providers to insureds, the travel times and distances to participating providers; • Sample participating provider agreement; and, • Listing of providers by specialty type by county. *Note: The Department will not permit more than a 30% differential between in-network and out-of-*	

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		network coverage unless supported by scholarly literature or actual claims experience of the insurer.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for SHOP On-Exchange Plans and Off-Exchange Plans" has been posted on the Department website and on SERFF.** *Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.* *For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.*	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3221 11NYCRR52.40(e) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Small Group: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(l)(5). c. Actuarial justification for the use of claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio _____ %.	See Actuarial Memorandum
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	See Actuarial Memorandum
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	See Actuarial Memorandum
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	See Actuarial Memorandum
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: _____ %.	See Actuarial Memorandum

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GROUP RATE MANUAL	11NYCRR52.40(e)(2) §3231(e)(1)(B) §4308 (c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		*Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.* *(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)*	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	11NYCRR52.40(e)	a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. b. History of previous New York rate revisions. c. Provide New York and nationwide claims experience respectively, including: (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. d. Actuarial justification of proposed rates revision (increase/decrease). e. Non-claim expense components as a percentage of gross premium. f. Impact on rates as a result of each of the changes with actuarial justification. g. Expected loss ratio(s) after the proposed changes.	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans". c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: _____ %.	
REVISED RATE MANUAL PAGES	11NYCRR52.40(e)(2)	a. Table of contents. b. Rate pages.	

		c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	

GROUP HEALTH INCORPORATED

This is to certify that the form(s) listed on the attached page(s) are in compliance with the New York Insurance Policy Readability Law.

A. **Option Selected**.

☐ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined is _____.

☒ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated on the attached page(s).

B. **Test Option Selected**.

☒ 1. Test was applied to entire policy form(s).

☐ 2. Test was applied to sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. **Standards of Certification**. A check box indicates the noted standard(s) has been achieved.

☐ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

☒ 2. The policy text does not achieve a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above; however, the lower score should be approved in accordance with Section 3102(d) of the Insurance Law.

☒ 3. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables).

☒ 4. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

☒ 5. The section titles are captioned in bold face or otherwise, stand out, significantly from the text.

☒ 6. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

☒ 7. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

☐ 8. A table of contents or an index of the principal section is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages).

Flesch scores for form(s) submitted with this filing are:

Form No	Flesch Score
HCR-OX-100	32.7

[redacted]

Corporate Secretary, Senior Vice President, Deputy General Counsel

Date: May 29, 2013

GROUP HEALTH INCORPORATED

This is to certify that the form(s) listed on the attached page(s) are in compliance with the New York Insurance Policy Readability Law.

A. **Option Selected**.

☐ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined is _____.

☒ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated on the attached page(s).

B. **Test Option Selected**.

☒ 1. Test was applied to entire policy form(s).

☐ 2. Test was applied to sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. **Standards of Certification**. A check box indicates the noted standard(s) has been achieved.

☐ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

☒ 2. The policy text does not achieve a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above; however, the lower score should be approved in accordance with Section 3102(d) of the Insurance Law.

☒ 3. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables).

☒ 4. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

☒ 5. The section titles are captioned in bold face or otherwise, stand out, significantly from the text.

☒ 6. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

☒ 7. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

☐ 8. A table of contents or an index of the principal section is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages).

Flesch scores for form(s) submitted with this filing are:

Form No	Flesch Score
HCR-OXR-CC	31.7

[redacted]

Corporate Secretary, Senior Vice President, Deputy General Counsel

Date: May 29, 2013

GROUP HEALTH INCORPORATED

This is to certify that the form(s) listed on the attached page(s) are in compliance with the New York Insurance Policy Readability Law.

A. **Option Selected**.

☐ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined is _____.

☒ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated on the attached page(s).

B. **Test Option Selected**.

☒ 1. Test was applied to entire policy form(s).

☐ 2. Test was applied to sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. **Standards of Certification**. A check box indicates the noted standard(s) has been achieved.

☒ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

☐ 2. The policy text does not achieve a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above; however, the lower score should be approved in accordance with Section 3102(d) of the Insurance Law.

☒ 3. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables).

☒ 4. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

☒ 5. The section titles are captioned in bold face or otherwise, stand out, significantly from the text.

☒ 6. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

☒ 7. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

☐ 8. A table of contents or an index of the principal section is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages).

Flesch scores for form(s) submitted with this filing are:

Form No	Flesch Score
HCR-OXR-A29	47.0

[redacted]

Corporate Secretary, Senior Vice President, Deputy General Counsel

Date: May 29, 2013

GROUP HEALTH INCORPORATED

This is to certify that the form(s) listed on the attached page(s) are in compliance with the New York Insurance Policy Readability Law.

A. **Option Selected**.

☐ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined is _____.

☒ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated on the attached page(s).

B. **Test Option Selected**.

☒ 1. Test was applied to entire policy form(s).

☐ 2. Test was applied to sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. **Standards of Certification**. A check box indicates the noted standard(s) has been achieved.

☒ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

☐ 2. The policy text does not achieve a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above; however, the lower score should be approved in accordance with Section 3102(d) of the Insurance Law.

☒ 3. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables).

☒ 4. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

☒ 5. The section titles are captioned in bold face or otherwise, stand out, significantly from the text.

☒ 6. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

☒ 7. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

☐ 8. A table of contents or an index of the principal section is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages).

Flesch scores for form(s) submitted with this filing are:

Form No	Flesch Score
155-23-EMBLEMAPP-OX14	56.5

[redacted]

Corporate Secretary, Senior Vice President, Deputy General Counsel

Date: May 29, 2013

GROUP HEALTH INCORPORATED

This is to certify that the form(s) listed on the attached page(s) are in compliance with the New York Insurance Policy Readability Law.

A. **Option Selected**.

☐ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined is _____.

☒ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated on the attached page(s).

B. **Test Option Selected**.

☒ 1. Test was applied to entire policy form(s).

☐ 2. Test was applied to sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. **Standards of Certification**. A check box indicates the noted standard(s) has been achieved.

☐ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

☒ 2. The policy text does not achieve a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above; however, the lower score should be approved in accordance with Section 3102(d) of the Insurance Law.

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☐ 8. A table of contents or an index of the principal section is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages).

Flesch scores for form(s) submitted with this filing are:

Form No	Flesch Score
HCR-OX-GC1	42.7

[redacted]

Corporate Secretary, Senior Vice President, Deputy General Counsel

Date: May 29, 2013

Group Health Incorporated (GHI)
HIOS Issuer ID #88000, NAIC #55239

RATE FILING FOR SMALL GROUP OFF EXCHANGE PRODUCT
ACTUARIAL MEMORANDUM

The purpose of this actuarial memorandum is to provide the details required for GHI 's 2014 premium rate filing for a new EPO product to be sold outside of New York's Small Group Health Benefit Exchange. The proposed premium rates are based on a rolling rate structure with effective dates of January - March 2014 (1Q14), April – June 2014 (2Q14), July – September 2104 (3Q14) and October - December 2014 (4Q14) and will be available to groups all eight rating regions in New York state.

Product Listing

GHI will be offering a Bronze plan design:

Product Name	Metal Tier	Standard Plan Design
EmblemHealth Tri-State EPO HD6300	Bronze (AV = **.582**)	No

The HHS Actuarial Value (AV) Calculator was used to determine the AV metal tier.

- A listing of all plans in the Small Group Risk Pool is attached as **Appendix A**.
- A listing of all plan cost sharing features and benefits are included in **Appendix B.**
- Printouts of the HHS AV Calculator page for each plan design are provided in **Appendix C.**
- Descriptions of the quality improvement and cost containment programs that will impact these new plans are in **Appendix D**

Please note that the Appendices are not consecutively lettered. The appendix names correspond to those in the HIP Individual Exchange rate filing and any unnecessary appendixes have been omitted.

Index Rate Determination

The new GHI small group off exchange plan will comprise GHI 's single risk pool in the small group market. All existing GHI small group plans will be discontinued effective January 1, 2014.

GHI has determined an index rate and adjusted index rate for the small group risk pool using permissible market wide adjustments. GHI then used plan level adjustments to develop plan specific rates which conform to the New York State's standardized census tiers. All plan specific rates will be based on the same standard population with no differences in rates due to age, sex occupation or health status.

Experience Period Claims

GHI currently participates in the small group market and is using its small group claims experience as a starting point to determine the premiums rates for the Off Exchange small group plans.

GHI's existing small group product portfolio consists of:

- GHI Small Group: EPO, InBalance EPO, CDHP EPO, PPO, CDHP PPO, SBAP, and a Trade Assistance product. GHI also currently offers a Healthy New York EPO product, but this was excluded from the claims experience since GHI does not intend to offer a Healthy New York product in 2014.

Inpatient, outpatient, professional and prescription drug paid claim experience for GHI's members (excluding the impact of the current Regulation 146) was compiled by product and neighborhood cohort for claims incurred from October 2011 through September 2012 paid through December 2012. Note that claims include the NYHCRA surcharge. Claims were completed using completion factors provided by the EmblemHealth Valuation Unit.

Note that prescription drug experience was adjusted to reflect that cost sharing was not taken on CDHP prescription claims in the first part of 2012. Per **Appendix S**, this resulted in a reduction in the experience period of approximately $3.82 PMPM.

Exhibit 7: Historical Data: displays the Department's template completed for each of GHI's current small group products. For purposes of this rate filing, we have used the following experience periods:

Most Recent Experience Period – The source data for this filing is experience from October 2011 through September 2012 with recast adjustments to reflect claims run out through December 2012.

First Prior Experience Period – The first prior experience period is January 2011 through December 2011 with recast adjustments through December 2012.

Second Prior Experience Period – The prior experience period is January 2010 through December 2010 with recast adjustments through December 2012.

Standardized Premium

Appendix E provides the support for the development of standardized premiums for the experience periods which are displayed in Exhibit 7.

For the base experience, factors for each policy form and market segment grouping were developed to determine the relationship between base earned premiums and 2013 standardized premiums. All rates used in this development were from the 2010 through 2013 GHI Rate Manuals.

In this development, January 2011 – December 2011 average weighted [individual] small group employee rates were used as a proxy for the prior base period earned premium PMPMs. These were developed first by calculating a blended base rate for each month of renewal. For example, for a February 2011 renewal, the average prior period rate reflects one month of the 1st Quarter 2010 rate and 11 months of the 1st quarter 2011 rate as displayed below:

February 2011 Average Rate = [(1 * Q1 2010 Rate) + (11 * Q1 2011 Rate)] / 12

Once the blended base rate premium was developed for each renewal month, these were assigned weights based upon the proportion of total premiums received by renewal month. This weighting of the blended base rates resulted in the prior period average weighted rate.

The 4th quarter 2013 rates were then divided by the 2011 average weighted rates to develop factors at the policy form and market segment level of detail described above. These factors were multiplied by the prior base period earned premium in order to calculate the standardized premium at the same level of detail and which are summarized in the prior experience period section of the summary template.

The same approach was used to develop factors measuring the relationship between 4th quarter 2013 rates and the base period average weighted small group employee rates. These factors were similarly applied to the October 2011 – September 2012 earned premiums in order to develop the standardized premium in the most recent experience period section of the summary template.

Note that the standardized premium calculation does not reflect shifts in membership or changes in underlying benefits experienced over the last several years.

Credibility of Experience

The small group pool is fully credible under NAIC guidelines. The small group pool is also fully credible under GHI's filed experience-rated methodology.

Trends

The components of GHI's medical trend factors are shown in **Appendix F** and exclude any changes included as part of the market wide adjustments described later in this Actuarial Memorandum. GHI is utilizing the trends as filed in GHI's 2013 Prior Approval filing (SERFF # GRPH-128540961 [Small Group] and SERFF # GRPH-128540919 [Individual]) except as noted below. It is assumed that the 2013 trends will be a reasonable estimate of trends into 2014.

- Unit Cost – the unit cost trend has been updated to reflect expected contracted increases for our most frequently utilized facilities and mix of services.
- Utilization - This assumption represents "pure" utilization independent of changes in underlying demographics and risk of the population and there are no changes from GHI's 2013 Prior Approval rate filing except for inpatient facility utilization. Inpatient facility utilization projections have been updated to reflect the underlying trends for a stable population with consistent risk characteristics over time. To develop these projections, we look at long term utilization trend for our Large Group HMO business, other large group business, and hospital association statistics from the American Hospital Association, health care trend surveys and reports, and federal government data including MedPac reports at www.medpac.go, in additional to conversations with our clinicians.
- Risk Score - The risk score component was largely based upon historical trends in prospective DCG risk scores (see **Appendix G**). DCG Prospective risk scores are an industry standard indicator of a population's future costs. The SOA Risk Score Study (http://www.soa.org/research/research-projects/health/hlth-risk-assement.aspx) contains

information on the accuracy of risk models. This component of trend remains unchanged from our 2013 Prior Approval filing.

- Provider Mix: This component measures the trend attributable to services moving to more expensive facilities and is unchanged from GHI's 2013 Prior Approval filing since we expect these trends to continue. Provider mix was determined by calculating the weighted average cost for facility claims for successive years where the weight is the facility specific share of total facility spend for each year and the cost per facility is the average admit cost in the second year. We have observed over time that there is a migration of business to higher cost facilities because lower cost facilities are more like to have financial problems and close or be acquired by higher cost systems. Also, the higher cost facilities are more likely to use direct to consumer advertising thus attracting more of our members. Higher cost facilities also are investing more in equipment and physical plant which attracts physicians to use these facilities.

Medical trends in **Appendix F** were applied using the following formula to derive the average 2014 claims PMPM projections for groups enrolling in the first quarter of 2014.

$$\text{2014 claims PMPM} = [\text{4Q11-3Q12 PMPM}]^* [(1+ \text{2012 trend \%})^{3/12}]^* [(1 + \text{2013 trend \%})^{25/12}]$$

Adjustments to the Projection Period Claims

The following market wide adjustments were applied to the projected 2014 claims PMPMs:

Expected Member Mix: We are projecting a shift in the regional membership mix and product mix for the new small group membership based on our marketing strategies for the new small group products. This results in an adjustment of **-3.5%** when comparing our initial trended claim cost based on our current member mix versus our updated trended claim cost based on our projected member mix as shown in **Appendix H-1**.

Pharmacy Adjustments

- GHI changed its drug formulary which was applicable to small group products effective June 1, 2012. As such, this change was in effect for only a portion of the experience period. A reduction of $**3.15** PMPM was removed from the claims to adjust Rx claims for the period 10/1/2011-5/31/2012 when the formulary change was not in effect.
- Rebates – the base claims experience excludes the reduction of prescription drug cost due to rebates. We are assuming a rebate percentage of **9.8**% of claims for 2014.
- Prescription drugs - A portion of GHI's existing small group members do not have prescription drug coverage or have generic only drug coverage. The adjustments to bring drug coverage up to the EHB levels were determined using GHI's small group experience is **16.4**% of Pharmacy expense.

Compliance with Essential Health Benefits – The items listed below identify the significant adjustments used to bring all current plans in compliance with the Essential Health Benefits for a total market wide adjustment of $**10.77**. These are summarized in **Appendix J**.

- Women's Health – Benefits associated with the ACA Women's Preventive Mandate became effective on August 2012 and is partially included in our experience period date. The remaining costs totaling an average of **$4.58** has been added to our projections. These costs are based on GHI's Women's Health rate filing approved in SERFF # GRPH-128377420**.**
- NY State Autism Mandate – Benefits associated with the New York State Autism mandate became effective on November 2012. Costs of **$3.78** have been added to our projections for this mandate. These costs are based on GHI's Autism mandate rate filing approved in SERFF # GRPH-128427624**.**
- Mental Health and Substance Abuse – GHI's existing benefit plans generally have limited mental health and substance abuse benefits. To determine the cost increase to extend the benefits to unlimited days or visits, GHI's approved Mental Health Parity rider rates were used to estimate the additional cost of $**3.41** PMPM to shift from limited behavioral health benefits to unlimited behavioral health benefits.
- An additional $**1.00** PMPM has been removed for expected reductions in costs due to changes from the current Small Group formulary to GHI's new Exchange/Off Exchange formulary. Note that GHI's new formulary does meet all EHB requirements.

All other benefit adjustments to comply with EHB have a minimal impact to claims costs.

Provider Network Changes (including Fee Schedule Changes) – there are no anticipated changes in network providers or fee schedules.

Pricing Actuarial Value (AV) Adjustments - Actuarial value (AV) pricing values were determined using a benefit pricing model based on GHI 's claims experience incurred October 2011 through September 2012 paid through December 2012 plus completion factors to account for claim incurred but not reported. The AV pricing values identify the relative value between plans due to changes in cost sharing and do not reflect induced demand which is the differences in spending pattern attributable to the richness of the plan design.

The AV of the current GHI experience described above is **77.78**%. The AV of GHI's small group membership is expected to be **61.85**%. The development of the Pricing AV for each plan design is described below. The resulting ratio of **61.85%/77.78% (.7952**) was applied to the projected costs to take into account the higher cost sharing anticipated in the GHI small group membership.

Induced Demand Adjustments

For our current GHI experience, we used the following induced demand factors based on the Induced Demand factors included in the HHS final rules re Risk Adjustment:

- 1.00 for Bronze Metal Products
- 1.03 for Silver Metal Products
- 1.08 for Gold Metal Products
- 1.15 for Platinum Metal Products

Induced demand was demonstrated and quantified in the Rand Health Insurance Experiment. These adjustments for induced demand do not reflect differences in the health status of our members.

Note that we interpolated Induced Demand factors based on the AV of the current plan designs. The resulting composite induced demand factor based on our current GHI experience was **1.0738.**

We then calculated expected Induced Demand for GHI's small group membership based on expected membership distribution by product and the HHS' induced demand factors above. The result is an expected Induced Demand factor of **1.0000**.

The resulting ratio of **1.0000/1.0738 (0.9313)** was applied to projected claim costs to take into account the lower induced demand anticipated in the GHI small group membership.

Index Rate
The resulting GHI small group Index rate is **$341.82** PMPM per row 22 of **Appendix P.**

Adjustments to Index Rate

Federal Risk Adjustment Program – The results provided by the Department of Financial Services for the risk adjustment simulation were applied to the pricing of the small group products. Per **Appendix N-2**, the projected Risk Adjustment payment is estimated to be $**62.72** PMPM.

The resulting GHI small group Adjusted Index Rate is $**404.55** PMPM per row 25 of **Appendix P.**

Plan-Design Level Rate Adjustments

The following adjustments were made to develop plan-specific PMPM rates from the adjusted index rate.

Pricing AV by plan design
To develop Pricing AV, we took the projected GHI experience described above, but used allowed claim expenses. Continuance tables were then built to determine a Paid/Allowed ratio for the proposed GHI plan designs. The Pricing AV was applied to the Index Rate described above, since the Risk Adjustment PMPM was applied separately per below.

The Pricing AV for each plan design was then divided by the average Pricing AV included in the adjusted index rate described above.

Induced Demand
The induced demand for each plan design was calculated using HHS's induced demand factors described above. The induced demand for each plan design was then divided by the average induced demand included in the adjusted rate described above.

Risk Adjustment PMPM
The Risk Adjustment PMPM described above was applied to each plan design to determine the plan-specific PMPM cost.

Provider Network, Delivery System, and Utilization Management Practice Adjustments – There are no provider network, delivery system or utilization management adjustments specific to plan design.

Plan-Specific PMPM costs
The resulting plan-specific PMPM cost of **$405.55** is shown in row 39 of **Appendix P**.

Other Adjustments to Plan-Specific PMPM costs

Covered Lives Assessment (CLA)
Covered Lives Assessment was then added to the PMPM costs. The CLA is based on expected Small Group membership. We assumed a **2**% trend from 2013 to 2014 for CLA.

ACA Fees
The derivation of ACA fees is as follows:

- Insurer Fee: This nation-wide fee associated with PPACA of $8 Billion will be spread to all eligible carriers based upon earned 2014 premiums with some exclusions. This fee is anticipated to cost **1.5%** of 2014 premium and is included in the "Other state and federal taxes and assessments" column of the standard Exhibit 9.
- Reinsurance Assessment: This assessment is expected to add $**5.25** PMPM to 2014 earned premium and is included in the "Other state and federal taxes and assessments" column of the standard Exhibit 9.
- PCORI Fee: This fee is anticipated to cost about $**2.10** PMPY, or $**0**.**175** PMPM for 2014 and is included in the "Other state and federal taxes and assessments" column of the standard Exhibit 9.
- Federal Risk Adjustment Program Fee: Plans will be charged a **$0.96** PMPMY fee, or $.**08** PMPM fee for the Federal Risk Adjustment Fee and has been included the "Other state and federal taxes and assessments" column of the standard Exhibit 9.

Administrative Expenses and Margin –
Please refer to Standard Exhibit 9, which contains the projected 2014 administrative expense components for each of the 2014 plan designs.

The derivation of expenses are discussed below:

- Section 332 Assessments: This is expected to be **0**.**95**% of 2014 premiums.
- Activities that Improve Health Care Quality (as defined in the NAIC Annual Statement Supplement Health Care Exhibit): This is expected to be **0.70**% of 2014 premiums. Please refer to Appendix D for a description of these activities.
- Commissions and broker fees: This is expected to be **0**% since we do not intend to pay commissions for the new GHI Small Group product in 2014.
- GA Payments: This is expected to be **$0.00** PMPM since we do not intend to pay General Agents for the new GHI Small group product in 2014.
- Premium Taxes: GHI is not subject to premium taxes
- Other administrative expenses: This is expected to be **6.50**%.
- Margin: We include a **1**% margin in the development of our premium rates.

PMPM rates
The resulting plan specific PMPM premium rate is shown in row 54 of **Appendix P**.

Calculating Premium Rates by Tier and Region

Regional rate adjustments
To calculate the premium rates by region, we used differences in Allowed Claim Cost divided by the risk adjustment risk scores for our GHI membership for the Downstate, Long Island, and Mid-Hudson rating regions. The result is a "risk-normalized" Allowed Claim Cost by region. As shown in **Appendix Q**, we calculated a regional factor of **0.955** for the New York City rating region and a regional factor of **1.029** for the Long Island rating region, and **0.979** for the Mid-Hudson rating region. Due to the extremely low membership in other rating regions (Albany, Buffalo, Rochester, Syracuse, Utica/Watertown), we used a blend of the currently approved rating region factors for our current GHI Small Group products.

PEPM to Individual rate conversion factor and Family Rate tiers
We have mapped the membership from GHI's current product portfolio as a basis to project the expected membership distribution for the small group Products as shown in **Appendix R** to calculate the single conversion factor of **1.206.**

Quarterly Step up Factors
Premium rates for 2Q14, 3Q14 and 4Q14 have been developed using the annual trend rates described previously plus the impact of changes in the ACA fees. The derivation of the **3.1%** quarterly step ups are shown in **Appendix R-1.**

A premium rate manual has been included which conforms to the New York State's standardized census tiers

Age 29 Rider
All metal level plans include an optional age 29 rider which extend coverage to unmarried, uninsured adult children up through age 29. The age 29 rider was priced using the adjustment factor of **2.1**% as shown in **Appendix T.** The current 4.0% Age 30 factor shown in Exhibit T is the current approved Age 30 factor for GHI's 4-tier Small Group business.

Domestic Partner Rider
GHI will be providing domestic partner coverage at no additional cost.

Pediatric Dental
Pediatric dental will not be offered as an embedded benefit in GHI's off exchange product portfolio and rates for pediatric coverage are not included in the premium rate manual. We are in the process of arranging a contract with Dentcare Delivery Systems to provide stand-alone pediatric benefits to our members.

Loss Ratio

The requested premium rates result in an **88.2**% target loss ratio based on the above assumptions.

Standard Exhibits

Please note the following regarding the following standardized exhibits:

- Exhibit 7: All GHI small group products in the experience period of 4Q2011-3Q2012 are shown. As discussed in the "Expected Member Mix" section above, we used current member mix as the starting point to determine our projected "Exchange" member mix.

- Exhibit 8: Please note the following regarding Exhibit 8:
  - Please note the CLA, ACA Fees, and Administrative costs are not shown in Exhibit 8. These are shown in Appendix P. Line # 42 of Exhibit 8 corresponds to row 39 of Appendix P.
  - Pricing Actuarial Values:
    - In Appendix P, we apply the following adjustments:
      - Index Rate calculation
        - Row 13 shows current Pricing AV for the Experience Period **(0.7778)**
        - Row 14 shows expected Pricing AV for the small group Market **(0.6185)**
        - Row 15 shows the ratio of Row 14 / Row 13 **(0.7952** = **0.6185/0.7778)**. This reduced the paid claim cost in the Index rate to reflect the higher cost sharing anticipated in the Exchange.
      - Plan specific calculation
        - Row 29 is the plan-specific Pricing AV calculated for each plan (e.g., **0.6185** for Bronze)
        - Row 30 is the expected Pricing AV for the small group Market **(0.6185**)
        - Row 31 is the ratio of Row 30 / Row 29 (e.g., **1.0000 = 0.6185/0.6185**)
    - In Exhibit 8:
      - Line # 11 corresponds to Row 13 of Appendix P
      - Line # 26 corresponds to Row 14 of Appendix P
      - Line # 28 corresponds to Row 29 of Appendix P
      - Line # 39 corresponds to Row 30 of Appendix P
  - Line 10B corresponds to the Member Months from Exhibit 7. As discussed above and summarized in **Appendix H-1**, the initial projected claims cost for Off-Exchange membership was based on existing membership, and then adjusted for expected "Off-Exchange" member mix.
  - **Appendix S** shows how the $**338.23** PMPM in Line # 10C was derived based on the $**449.28** PMPM in row 1 of **Appendix P**. In essence, this represents untrended base experience adjusted for certain items shown in Appendix P.

- Exhibit 9: A comparison of the ACA Fees and Administrative expenses in Exhibit 9 to the ACA Fees and Administrative expenses in Exhibit 2 of GHI's 2013 Small Group's Prior Approval filing is as follows:
  - 332 Assessments, etc.: Assumed **0.95**% in both filings

- Administrative expenses that improve HC quality: Note that in the 2013 Prior Approval filing, this was classified as a "claims" expense when calculating our premium rate. The **0.70**% used for the 2014 Off-Exchange filing
- Commissions: We have recently filed for a 0% commission rate on our small group products which will apply to our new 2014 products. We assumed **6.0%** were paid in our 2013 Small Group Prior Approval filing.
- Other federal fees and assessments: This increased from **0.3%** for 1Q2013 to **2.68%** due to the new ACA fees described above that will become effective in 2014.
- Other administrative expenses: This was reduced from **7.77**% in the 2013 Prior Approval filing to **6.5**% in the 2014 Off Exchange filing.

Uniform Rate Review Template

Worksheet 1 of the Unified Rate Review Template (URRT): Worksheet 1 does not demonstrate the process used to develop the rates. It represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The Experience Period in the URRT contains incurred 2012 claims. These claims were derived from allowed claims, incurred from October 2011 through September 2012 paid through December 2012 (plus appropriate completion factors), trended forward 3 months. Trend, market wide factors and expense loads as previously described in this actuarial memorandum were applied to the experience period claims to project 2014 experience. Note that these factors have been adjusted to reflect the differences in URRT base period data.

As previously stated, this exhibit provides information required by Federal regulation and does not demonstrate the process to develop rates.

Actuarial Certification

I am a Member of the Society of Actuaries and member of the American Academy of Actuaries; and meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.

I further certify that to the best of my knowledge:

1. This filing, including the projected index rate, is in compliance with all applicable New York State and Federal laws and regulations (45 CFR 156.80(d)(1)).
2. The filing is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
    - ASOP No. 5, Incurred Health and Disability Claims
    - ASOP No. 8, Regulatory Filings for Health Plan Entities
    - ASOP No. 12, Risk Classification
    - ASOP No. 23, Data Quality

- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 41, Actuarial Communications

3. The expected loss ratio incorporated into the proposed rate tables meets the minimum requirement of the State of New York.
4. The benefits are reasonable in relation to the premiums charged.
5. The rates are not unfairly discriminatory.
6. Only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
7. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans with one adjustment for outpatient copays as described above in the Actuarial Memorandum. The adjustment was developed in accordance with generally accepted actuarial principles and methodologies.

Please keep all information contained in this rate filing confidential.

[redacted]

[redacted]
Senior Actuary, EmblemHealth Actuarial Services
[redacted]

Appendix C

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,300.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.16369%
Metal Tier:	Bronze

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:

Group Health Incorporated	Not-For-Profit - 43	Not-for-Profit	55239
Company submitting the rate adjustment request	Company Type	Org. Type	Company NAIC Code

55 Water St. New York, NY, 10041
Company mailing address

B. Contact Person:

[redacted] Sr. Actuary	[redacted]	[redacted]
Rate filing contact person name, title	Contact phone number	Contact Email address

C. Actuarial Contact (If different from above):

Actuary name, title	Actuary phone number	Actuary Email address

D. New Rate Information (See Note #1):

1/1/2014-12/31/2014	01/01/2014	GRPH-129013148
New rate applicability period	New rate effective date	SERFF Tracking Number

E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement): Small Group, Sole Proprietors

F. Provide responses for the following questions:

	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	No
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	No
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3).	N/A
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefiling.	No

Notes:

(1) It is recommended that a rate filing application subject to §3231(e)(1) or §4308(c) of the New York Insurance Law be submitted at least 150 days before the proposed effective date.
It is recommended that a rate adjustment application not be submitted more than 180 days prior to the proposed effective date.
It is recommended that a rate adjustment application not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing.

(2) A rate adjustment filing submitted pursuant to §3231(e)(1) or §4308(c) of the New York Insurance Law should **not** include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing, a new form or a revision to an existing form, must be a separate filing from the rate adjustment filing.

Use the following SERFF filing types for rate adjustment filings:

* For a rate adjustment filing pursuant to §3231(e)(1): Rate Adjustment pursuant to §3231(e)(1)
* For a rate adjustment filing pursuant to §4308(c): Rate Adjustment pursuant to §4308(c)
* For all other prior approval filings: Normal Pre-Approval

(3) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment application is submitted to the Insurance Department.

EXHIBIT 7: HISTORICAL DATA BY EACH POLICY FORM INCLUDED IN RATE ADJUSTMENT FILING

Company Name: GHI
NAIC Code: 55239
SERFF Number: GRPH-129013148

A. Complete a separate ROW for each base medical policy form included in the rate adjustment filing, even if no rate adjustment is proposed for that base medical policy form.
- Information requested applies to New York State business only.
- Include riders that may be available with that policy form in each policy form response.
- Insert additional rows as needed to include all base medical policy forms included in a particular rating pool.
- Add a row with the aggregate values for that entire rating pool and enter an appropriate identifier in column 1a. Skip a row between the different rating pools.

B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG HMO Upstate if rating pools vary by rating region.
C. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare
D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans, Hospital Only, Medical Only, Base+Supplemental,
E. The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department). Include a region
F. Note that many cells include a drop down list. Use the drop down list for entries.
G. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
H. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identifier	3. Effective date of rate change (MM/DD/YY)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change
PLH-SGC-976	GHI-PPO	GHI-PPO	SG	01/01/2014	SG	PPO	Yes	Open	510	2,266
PLH-EPO-100	GHI-EPO	GHI-EPO	SG	01/01/2014	SG	EPO	Yes	Open	8,742	62,888
PLH-SGC-1003	Small Business Advantage	SBAP	SG	01/01/2014	SG	PPO	Yes	Open	209	354
GHI-TAA-101-2003	Trade Adjustment Assistance	HCTC	SG	01/01/2014	SG	EPO	Yes	Open	22	26
PLH-SGC-994	EPO Share	EPO Share	SG	01/01/2014	SG	EPO	Yes	Open	2,810	19,596
PLH-SGC-1000	HSA Compatible PPO	CDHP PPO	SG	01/01/2014	SG	PPO	Yes	Open	349	1,802
PLH-SGC-997	HSA Compatible EPO	CDHP EPO	SG	01/01/2014	SG	EPO	Yes	Open	1,873	13,596
	Total								14,515	100,528

EXHIBIT 7: HISTORICAL DATA BY EACH POLICY FORM INCLUDED IN RATE ADJUSTMENT FILING

			Most Recent Experience Period										
1a. Base medical policy form number	1b. Product Name as in Rate Manual		14.1 Beginning Date of the experience period (MM/DD/YY)	14.2 Ending Date of the experience period (MM/DD/YY)	14.3 Member months for experience period	14.4 Earned premiums for experience period ($)	14.5 Standardized earned premiums for experience period ($)	14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	14.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	14.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)
PLH-SGC-976	GHI-PPO	XX	10/01/2011	9/30/2012	41,408	31,230,631	38,306,374	19,345,114	33,618,612	0	(1,202,832)	5,225,122
PLH-EPO-100	GHI-EPO	XX	10/01/2011	9/30/2012	734,562	304,240,826	376,372,753	203,484,390	272,996,840	0	6,330,995	50,880,946
PLH-SGC-1003	Small Business Advantage	XX	10/01/2011	9/30/2012	6,644	4,706,284	5,813,264	2,475,582	3,855,113	0	(209,206)	787,421
GHI-TAA-101-2003	Trade Adjustment Assistance	XX	10/01/2011	9/30/2012	373	332,548	407,591	55,902	417,392	0	(12,833)	55,623
PLH-SGC-994	EPO Share	XX	10/01/2011	9/30/2012	283,425	97,003,504	119,602,301	56,772,662	77,370,090	0	1,889,088	16,225,237
PLH-SGC-1000	HSA Compatible PPO	XX	10/01/2011	9/30/2012	59,738	21,045,020	26,577,148	14,917,291	26,624,737	0	97,189	3,168,813
PLH-SGC-997	HSA Compatible EPO	XX	10/01/2011	9/30/2012	222,684	61,351,444	77,318,874	40,547,124	62,167,123	0	(2,526,392)	9,057,925
	Total	XX	10/01/2011	9/30/2012	1,348,834	519,910,259	644,398,305	337,598,064	477,049,907	0	4,366,008	85,401,087

EXHIBIT 7: HISTORICAL DATA BY EACH POLICY FORM INCLUDED IN RATE ADJUSTMENT FILING

			First Prior Experience Period										
1a. Base medical policy form number	1b. Product Name as in Rate Manual		15.1 Beginning date of the experience period (MM/DD/YY)	15.2 Ending Date of the experience period (MM/DD/YY)	15.3 Member months for experience period	15.4 Earned premiums for experience period ($)	15.5 Standardized earned premiums for experience period ($)	15.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	15.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	15.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)
PLH-SGC-976	GHI-PPO	XX	01/01/2011	12/31/2011	61,115	42,267,273	58,533,530	39,062,255	39,226,412	0	57,448	7,112,989
PLH-EPO-100	GHI-EPO	XX	01/01/2011	12/31/2011	772,359	299,090,037	416,500,621	268,083,302	269,278,943	0	726,017	50,293,612
PLH-SGC-1003	Small Business Advantage	XX	01/01/2011	12/31/2011	11,642	7,378,230	10,090,109	6,459,023	6,487,829	0	10,943	1,239,582
GHI-TAA-101-2003	Trade Adjustment Assistance	XX	01/01/2011	12/31/2011	498	407,214	553,436	321,237	322,540	0	468	68,553
PLH-SGC-994	EPO Share	XX	01/01/2011	12/31/2011	326,877	107,325,805	149,366,128	86,288,558	86,667,282	0	307,264	18,051,316
PLH-SGC-1000	HSA Compatible PPO	XX	01/01/2011	12/31/2011	107,203	34,595,452	48,796,395	40,716,278	40,860,196	0	100,771	6,648,760
PLH-SGC-997	HSA Compatible EPO	XX	01/01/2011	12/31/2011	324,834	86,046,824	120,679,787	81,203,035	81,507,436	0	305,344	16,535,608
	Total	XX	01/01/2011	12/31/2011	1,604,528	577,110,835	804,520,006	522,133,688	524,350,637	0	1,508,256	99,950,419

EXHIBIT 7: HISTORICAL DATA BY EACH POLICY FORM INCLUDED IN RATE ADJUSTMENT FILING

			Second Prior Experience Period										
1a. Base medical policy form number	1b. Product Name as in Rate Manual		16.1 Beginning date of the experience period (MM/DD/YY)	16.2 Ending Date of the experience period (MM/DD/YY)	16.3 Member months for experience period	16.4 Earned premiums for experience period ($)	16.5 Standardized earned premiums for experience period ($)	16.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	16.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	16.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)
PLH-SGC-976	GHI-PPO	XX	01/01/2010	12/31/2010	142,956	76,583,157	139,915,982	72,794,345	72,962,534	0	484,621	8,783,217
PLH-EPO-100	GHI-EPO	XX	01/01/2010	12/31/2010	933,508	320,118,535	526,066,529	291,125,837	291,817,112	0	3,164,592	57,354,732
PLH-SGC-1003	Small Business Advantage	XX	01/01/2010	12/31/2010	4,993	2,979,328	4,387,827	2,723,065	2,729,876	0	16,926	306,770
GHI-TAA-101-2003	Trade Adjustment Assistance	XX	01/01/2010	12/31/2010	439	310,436	496,869	233,547	234,319	0	1,488	26,972
PLH-SGC-994	EPO Share	XX	01/01/2010	12/31/2010	334,374	98,937,315	160,601,736	82,961,190	83,163,188	0	1,133,528	20,543,939
PLH-SGC-1000	HSA Compatible PPO	XX	01/01/2010	12/31/2010	183,165	42,804,616	71,737,660	49,182,692	49,326,333	0	620,929	5,729,401
PLH-SGC-997	HSA Compatible EPO	XX	01/01/2010	12/31/2010	376,023	82,711,867	138,251,811	85,109,252	85,360,874	0	1,274,718	11,761,999
	Total	XX	01/01/2010	12/31/2010	1,975,458	624,445,254	1,041,458,413	584,129,927	585,594,237	0	6,696,803	104,507,029

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: GHI
NAIC Code: 55239
SERFF Number: GRPH-129013148
Market Segment: Small Group

Line #	General	Separate column for each pl
1	Product*	EmblemHealth Tri-State EPO HD6300
2	Product ID*	88000NY026
3	Metal Level (or catastrophic)*	Bronze
4	AV Metal Value (HHS Calculator)*	58.2%
5	AV Pricing Value (total, risk pool experience based)*	61.9%
6	Plan Type*	CDHP EPO
7	Plan Name*	EPO HD6300
8	Plan ID*	88000NY0260001
9	Exchange Plan?*	No

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

	Experience Period Index Rate	
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period	456,212,119
10B	Member-Months for Latest Experience Period	1,348,834
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	338.23
11	Average Pricing Actuarial Value reflected in experience period	0.778
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**434.82**

Market Wide Adjustments to the AV
Adjusted Experience Period Index Rate

13	Impact of adjusting experience period data to EHB benefit level	1.024
14	Market wide adjustment for changes in provider network **	1.000
15	Market wide adjustment for fee schedule changes **	1.000
16	Market wide adjustment for utilization management changes **	1.000
17	Impact on risk pool of changes in expected covered membership risk characteristics **	1.000
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
19	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	1.183
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000
22	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.333
24	Expected/Current Induced Demand	0.931
25	Required Revenue for Catastrophic	1.000
26	Expected Pricing AV	0.619
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.930**

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.619
29	Pricing actuarial value (only the induced demand factor) #	1.000
30	Impact of provider network characteristics ##	1.000
31	Impact of delivery system characteristics ##	1.000
32	Impact of utilization management practices ##	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.000
35	Profit/Contribution to surplus margins	1.000
36	Impact of eligibility categories (catastrophic plans only)	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000
39	Expected Pricing AV	1.617
40	Other 2 (specify)	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.000**

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

\## Beyond what is reflected in Market Wide adjustments

42	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)**	**404.55**

EXHIBIT 9 - SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN AND INCLUDED IN CURRENT RATE APPLICATION

Company Name: GHI
NAIC Code: 55239
SERFF Number: GRPH-129013148
Market Segment: SG

A. Complete a separate ROW for Metal Level/Exchange product in the current new On/Off Exchange product filing.
- Information should be for all the benefits included in that plan design (medical, drugs, etc).
- Enter the Metal Tier the On/Off Exchange product belongs to using the drop down menu, or enter a value.
- Enter the On/Off Designation using the drop down menu.
- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

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

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

D. This form must be submitted as an Excel file and as a PDF file.

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	4.1 Period assumed - beginning date (MM/DD/YY)	4.2 Period assumed - ending date (MM/DD/YY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10
Bronze	Off Exchange	EPO HD6300	01/01/14	12/31/14	12.79%	0.95%	0.70%	0.00%	0.00%	2.68%	6.50%	10.83%	0.80%	0.00%	0.00%	0.20%	20.00%	0.00%	11.83%
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EXHIBIT 9 - SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN AND INCLUDED IN CURRENT RATE APPLICATION

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as $pmpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as $pmpm	12.3 Commissions and broker fees - as $pmpm	12.4 Premium Taxes - as $pmpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as $pmpm	12.6 Other administrative expenses - as $pmpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as $pmpm	14. State income tax component - as $pmpm	15. Federal income tax component - as $pmpm	16. Reduction for assumed net investment income - as $pmpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Bronze	Off Exchange	EPO HD6300	4.45	3.28	0.00	0.00	12.53	30.42	50.67	3.74	0.00	0.94	0.00	55.35
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EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:

Group Health Incorporated	Not-For-Profit - 43	Not-for-Profit	55239
Company submitting the rate adjustment request	Company Type	Org. Type	Company NAIC Code

55 Water St. New York, NY, 10041
Company mailing address

B. Contact Person:

[redacted]	[redacted]	[redacted]
Rate filing contact person name, title	Contact phone number	Contact Email address

C. Actuarial Contact (If different from above):

Actuary name, title	Actuary phone number	Actuary Email address

D. New Rate Information (See Note #1):

1/1/2014-12/31/2014	01/01/2014	GRPH-129013148
New rate applicability period	New rate effective date	SERFF Tracking Number

E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement): Small Group, Sole Proprietors

F. Provide responses for the following questions:

	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	No
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	No
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3).	N/A
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefiling.	No

Notes:

(1) It is recommended that a rate filing application subject to §3231(e)(1) or §4308(c) of the New York Insurance Law be submitted at least 150 days before the proposed effective date.
It is recommended that a rate adjustment application not be submitted more than 180 days prior to the proposed effective date.
It is recommended that a rate adjustment application not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing.

(2) A rate adjustment filing submitted pursuant to §3231(e)(1) or §4308(c) of the New York Insurance Law should **not** include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing, a new form or a revision to an existing form, must be a separate filing from the rate adjustment filing.

Use the following SERFF filing types for rate adjustment filings:

* For a rate adjustment filing pursuant to §3231(e)(1): Rate Adjustment pursuant to §3231(e)(1)
* For a rate adjustment filing pursuant to §4308(c): Rate Adjustment pursuant to §4308(c)
* For all other prior approval filings: Normal Pre-Approval

(3) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment application is submitted to the Insurance Department.

Group Health Incorporated (GHI)
HIOS Issuer ID #88000, NAIC #55239

RATE FILING FOR SMALL GROUP OFF EXCHANGE PRODUCT
ACTUARIAL MEMORANDUM

The purpose of this actuarial memorandum is to provide the details required for GHI 's 2014 premium rate filing for a new EPO product to be sold outside of New York's Small Group Health Benefit Exchange. The proposed premium rates are based on a rolling rate structure with effective dates of January - March 2014 (1Q14), April – June 2014 (2Q14), July – September 2104 (3Q14) and October - December 2014 (4Q14) and will be available to groups all eight rating regions in New York state.

Product Listing

GHI will be offering a Bronze plan design:

Product Name	Metal Tier	Standard Plan Design
EmblemHealth Tri-State EPO HD6300	Bronze (AV = **.582**)	No

The HHS Actuarial Value (AV) Calculator was used to determine the AV metal tier.

- A listing of all plans in the Small Group Risk Pool is attached as **Appendix A**.
- A listing of all plan cost sharing features and benefits are included in **Appendix B.**
- Printouts of the HHS AV Calculator page for each plan design are provided in **Appendix C.**
- Descriptions of the quality improvement and cost containment programs that will impact these new plans are in **Appendix D**

Please note that the Appendices are not consecutively lettered. The appendix names correspond to those in the HIP Individual Exchange rate filing and any unnecessary appendixes have been omitted.

Index Rate Determination

The new GHI small group off exchange plan will comprise GHI 's single risk pool in the small group market. All existing GHI small group plans will be discontinued effective January 1, 2014.

GHI has determined an index rate and adjusted index rate for the small group risk pool using permissible market wide adjustments. GHI then used plan level adjustments to develop plan specific rates which conform to the New York State's standardized census tiers. All plan specific rates will be based on the same standard population with no differences in rates due to age, sex occupation or health status.

Experience Period Claims

GHI currently participates in the small group market and is using its small group claims experience as a starting point to determine the premiums rates for the Off Exchange small group plans.

GHI's existing small group product portfolio consists of:

- GHI Small Group: EPO, InBalance EPO, CDHP EPO, PPO, CDHP PPO, SBAP, and a Trade Assistance product. GHI also currently offers a Healthy New York EPO product, but this was excluded from the claims experience since GHI does not intend to offer a Healthy New York product in 2014.

Inpatient, outpatient, professional and prescription drug paid claim experience for GHI's members (excluding the impact of the current Regulation 146) was compiled by product and neighborhood cohort for claims incurred from October 2011 through September 2012 paid through December 2012. Note that claims include the NYHCRA surcharge. Claims were completed using completion factors provided by the EmblemHealth Valuation Unit.

Note that prescription drug experience was adjusted to reflect that cost sharing was not taken on CDHP prescription claims in the first part of 2012. Per **Appendix S**, this resulted in a reduction in the experience period of approximately $3.82 PMPM.

Exhibit 7: Historical Data: displays the Department's template completed for each of GHI's current small group products. For purposes of this rate filing, we have used the following experience periods:

Most Recent Experience Period – The source data for this filing is experience from October 2011 through September 2012 with recast adjustments to reflect claims run out through December 2012.

First Prior Experience Period – The first prior experience period is January 2011 through December 2011 with recast adjustments through December 2012.

Second Prior Experience Period – The prior experience period is January 2010 through December 2010 with recast adjustments through December 2012.

Standardized Premium

Appendix E provides the support for the development of standardized premiums for the experience periods which are displayed in Exhibit 7.

For the base experience, factors for each policy form and market segment grouping were developed to determine the relationship between base earned premiums and 2013 standardized premiums. All rates used in this development were from the 2010 through 2013 GHI Rate Manuals.

In this development, January 2011 – December 2011 average weighted [individual] small group employee rates were used as a proxy for the prior base period earned premium PMPMs. These were developed first by calculating a blended base rate for each month of renewal. For example, for a February 2011 renewal, the average prior period rate reflects one month of the 1st Quarter 2010 rate and 11 months of the 1st quarter 2011 rate as displayed below:

February 2011 Average Rate = [(1 * Q1 2010 Rate) + (11 * Q1 2011 Rate)] / 12

Once the blended base rate premium was developed for each renewal month, these were assigned weights based upon the proportion of total premiums received by renewal month. This weighting of the blended base rates resulted in the prior period average weighted rate.

The 4th quarter 2013 rates were then divided by the 2011 average weighted rates to develop factors at the policy form and market segment level of detail described above. These factors were multiplied by the prior base period earned premium in order to calculate the standardized premium at the same level of detail and which are summarized in the prior experience period section of the summary template.

The same approach was used to develop factors measuring the relationship between 4th quarter 2013 rates and the base period average weighted small group employee rates. These factors were similarly applied to the October 2011 – September 2012 earned premiums in order to develop the standardized premium in the most recent experience period section of the summary template.

Note that the standardized premium calculation does not reflect shifts in membership or changes in underlying benefits experienced over the last several years.

Credibility of Experience

The small group pool is fully credible under NAIC guidelines. The small group pool is also fully credible under GHI's filed experience-rated methodology.

Trends

The components of GHI's medical trend factors are shown in **Appendix F** and exclude any changes included as part of the market wide adjustments described later in this Actuarial Memorandum. GHI is utilizing the trends as filed in GHI's 2013 Prior Approval filing (SERFF # GRPH-128540961 [Small Group] and SERFF # GRPH-128540919 [Individual]) except as noted below. It is assumed that the 2013 trends will be a reasonable estimate of trends into 2014.

- Unit Cost – the unit cost trend has been updated to reflect expected contracted increases for our most frequently utilized facilities and mix of services.
- Utilization - This assumption represents "pure" utilization independent of changes in underlying demographics and risk of the population and there are no changes from GHI's 2013 Prior Approval rate filing except for inpatient facility utilization. Inpatient facility utilization projections have been updated to reflect the underlying trends for a stable population with consistent risk characteristics over time. To develop these projections, we look at long term utilization trend for our Large Group HMO business, other large group business, and hospital association statistics from the American Hospital Association, health care trend surveys and reports, and federal government data including MedPac reports at www.medpac.go, in additional to conversations with our clinicians.
- Risk Score - The risk score component was largely based upon historical trends in prospective DCG risk scores (see **Appendix G**). DCG Prospective risk scores are an industry standard indicator of a population's future costs. The SOA Risk Score Study (http://www.soa.org/research/research-projects/health/hlth-risk-assement.aspx) contains

information on the accuracy of risk models. This component of trend remains unchanged from our 2013 Prior Approval filing.

- Provider Mix: This component measures the trend attributable to services moving to more expensive facilities and is unchanged from GHI's 2013 Prior Approval filing since we expect these trends to continue. Provider mix was determined by calculating the weighted average cost for facility claims for successive years where the weight is the facility specific share of total facility spend for each year and the cost per facility is the average admit cost in the second year. We have observed over time that there is a migration of business to higher cost facilities because lower cost facilities are more like to have financial problems and close or be acquired by higher cost systems. Also, the higher cost facilities are more likely to use direct to consumer advertising thus attracting more of our members. Higher cost facilities also are investing more in equipment and physical plant which attracts physicians to use these facilities.

Medical trends in **Appendix F** were applied using the following formula to derive the average 2014 claims PMPM projections for groups enrolling in the first quarter of 2014.

$$\text{2014 claims PMPM} = [\text{4Q11-3Q12 PMPM}]^* [(1+ \text{2012 trend \%})^{3/12}]^* [(1 + \text{2013 trend \%})^{25/12}]$$

Adjustments to the Projection Period Claims

The following market wide adjustments were applied to the projected 2014 claims PMPMs:

Expected Member Mix: We are projecting a shift in the regional membership mix and product mix for the new small group membership based on our marketing strategies for the new small group products. This results in an adjustment of **-3.5%** when comparing our initial trended claim cost based on our current member mix versus our updated trended claim cost based on our projected member mix as shown in **Appendix H-1**.

Pharmacy Adjustments

- GHI changed its drug formulary which was applicable to small group products effective June 1, 2012. As such, this change was in effect for only a portion of the experience period. A reduction of $**3.15** PMPM was removed from the claims to adjust Rx claims for the period 10/1/2011-5/31/2012 when the formulary change was not in effect.
- Rebates – the base claims experience excludes the reduction of prescription drug cost due to rebates. We are assuming a rebate percentage of **9.8**% of claims for 2014.
- Prescription drugs - A portion of GHI's existing small group members do not have prescription drug coverage or have generic only drug coverage. The adjustments to bring drug coverage up to the EHB levels were determined using GHI's small group experience is **16.4**% of Pharmacy expense.

Compliance with Essential Health Benefits – The items listed below identify the significant adjustments used to bring all current plans in compliance with the Essential Health Benefits for a total market wide adjustment of $**10.77**. These are summarized in **Appendix J**.

- Women's Health – Benefits associated with the ACA Women's Preventive Mandate became effective on August 2012 and is partially included in our experience period date. The remaining costs totaling an average of **$4.58** has been added to our projections. These costs are based on GHI's Women's Health rate filing approved in SERFF # GRPH-128377420**.**
- NY State Autism Mandate – Benefits associated with the New York State Autism mandate became effective on November 2012. Costs of **$3.78** have been added to our projections for this mandate. These costs are based on GHI's Autism mandate rate filing approved in SERFF # GRPH-128427624**.**
- Mental Health and Substance Abuse – GHI's existing benefit plans generally have limited mental health and substance abuse benefits. To determine the cost increase to extend the benefits to unlimited days or visits, GHI's approved Mental Health Parity rider rates were used to estimate the additional cost of $**3.41** PMPM to shift from limited behavioral health benefits to unlimited behavioral health benefits.
- An additional $**1.00** PMPM has been removed for expected reductions in costs due to changes from the current Small Group formulary to GHI's new Exchange/Off Exchange formulary. Note that GHI's new formulary does meet all EHB requirements.

All other benefit adjustments to comply with EHB have a minimal impact to claims costs.

Provider Network Changes (including Fee Schedule Changes) – there are no anticipated changes in network providers or fee schedules.

Pricing Actuarial Value (AV) Adjustments - Actuarial value (AV) pricing values were determined using a benefit pricing model based on GHI 's claims experience incurred October 2011 through September 2012 paid through December 2012 plus completion factors to account for claim incurred but not reported. The AV pricing values identify the relative value between plans due to changes in cost sharing and do not reflect induced demand which is the differences in spending pattern attributable to the richness of the plan design.

The AV of the current GHI experience described above is **77.78**%. The AV of GHI's small group membership is expected to be **61.85**%. The development of the Pricing AV for each plan design is described below. The resulting ratio of **61.85%/77.78% (.7952**) was applied to the projected costs to take into account the higher cost sharing anticipated in the GHI small group membership.

Induced Demand Adjustments

For our current GHI experience, we used the following induced demand factors based on the Induced Demand factors included in the HHS final rules re Risk Adjustment:

- 1.00 for Bronze Metal Products
- 1.03 for Silver Metal Products
- 1.08 for Gold Metal Products
- 1.15 for Platinum Metal Products

Induced demand was demonstrated and quantified in the Rand Health Insurance Experiment. These adjustments for induced demand do not reflect differences in the health status of our members.

Note that we interpolated Induced Demand factors based on the AV of the current plan designs. The resulting composite induced demand factor based on our current GHI experience was **1.0738.**

We then calculated expected Induced Demand for GHI's small group membership based on expected membership distribution by product and the HHS' induced demand factors above. The result is an expected Induced Demand factor of **1.0000**.

The resulting ratio of **1.0000/1.0738 (0.9313)** was applied to projected claim costs to take into account the lower induced demand anticipated in the GHI small group membership.

Index Rate
The resulting GHI small group Index rate is **$341.82** PMPM per row 22 of **Appendix P.**

Adjustments to Index Rate

Federal Risk Adjustment Program – The results provided by the Department of Financial Services for the risk adjustment simulation were applied to the pricing of the small group products. Per **Appendix N-2**, the projected Risk Adjustment payment is estimated to be $**62.72** PMPM.

The resulting GHI small group Adjusted Index Rate is $**404.55** PMPM per row 25 of **Appendix P.**

Plan-Design Level Rate Adjustments

The following adjustments were made to develop plan-specific PMPM rates from the adjusted index rate.

Pricing AV by plan design
To develop Pricing AV, we took the projected GHI experience described above, but used allowed claim expenses. Continuance tables were then built to determine a Paid/Allowed ratio for the proposed GHI plan designs. The Pricing AV was applied to the Index Rate described above, since the Risk Adjustment PMPM was applied separately per below.

The Pricing AV for each plan design was then divided by the average Pricing AV included in the adjusted index rate described above.

Induced Demand
The induced demand for each plan design was calculated using HHS's induced demand factors described above. The induced demand for each plan design was then divided by the average induced demand included in the adjusted rate described above.

Risk Adjustment PMPM
The Risk Adjustment PMPM described above was applied to each plan design to determine the plan-specific PMPM cost.

Provider Network, Delivery System, and Utilization Management Practice Adjustments – There are no provider network, delivery system or utilization management adjustments specific to plan design.

Plan-Specific PMPM costs
The resulting plan-specific PMPM cost of **$405.55** is shown in row 39 of **Appendix P**.

Other Adjustments to Plan-Specific PMPM costs

Covered Lives Assessment (CLA)
Covered Lives Assessment was then added to the PMPM costs. The CLA is based on expected Small Group membership. We assumed a **2**% trend from 2013 to 2014 for CLA.

ACA Fees
The derivation of ACA fees is as follows:

- Insurer Fee: This nation-wide fee associated with PPACA of $8 Billion will be spread to all eligible carriers based upon earned 2014 premiums with some exclusions. This fee is anticipated to cost **1.5%** of 2014 premium and is included in the "Other state and federal taxes and assessments" column of the standard Exhibit 9.
- Reinsurance Assessment: This assessment is expected to add $**5.25** PMPM to 2014 earned premium and is included in the "Other state and federal taxes and assessments" column of the standard Exhibit 9.
- PCORI Fee: This fee is anticipated to cost about $**2.10** PMPY, or $**0**.**175** PMPM for 2014 and is included in the "Other state and federal taxes and assessments" column of the standard Exhibit 9.
- Federal Risk Adjustment Program Fee: Plans will be charged a **$0.96** PMPMY fee, or $.**08** PMPM fee for the Federal Risk Adjustment Fee and has been included the "Other state and federal taxes and assessments" column of the standard Exhibit 9.

Administrative Expenses and Margin –
Please refer to Standard Exhibit 9, which contains the projected 2014 administrative expense components for each of the 2014 plan designs.

The derivation of expenses are discussed below:

- Section 332 Assessments: This is expected to be **0**.**95**% of 2014 premiums.
- Activities that Improve Health Care Quality (as defined in the NAIC Annual Statement Supplement Health Care Exhibit): This is expected to be **0.70**% of 2014 premiums. Please refer to Appendix D for a description of these activities.
- Commissions and broker fees: This is expected to be **0**% since we do not intend to pay commissions for the new GHI Small Group product in 2014.
- GA Payments: This is expected to be **$0.00** PMPM since we do not intend to pay General Agents for the new GHI Small group product in 2014.
- Premium Taxes: GHI is not subject to premium taxes
- Other administrative expenses: This is expected to be **6.50**%.
- Margin: We include a **1**% margin in the development of our premium rates.

PMPM rates
The resulting plan specific PMPM premium rate is shown in row 54 of **Appendix P**.

Calculating Premium Rates by Tier and Region

Regional rate adjustments
To calculate the premium rates by region, we used differences in Allowed Claim Cost divided by the risk adjustment risk scores for our GHI membership for the Downstate, Long Island, and Mid-Hudson rating regions. The result is a "risk-normalized" Allowed Claim Cost by region. As shown in **Appendix Q**, we calculated a regional factor of **0.955** for the New York City rating region and a regional factor of **1.029** for the Long Island rating region, and **0.979** for the Mid-Hudson rating region. Due to the extremely low membership in other rating regions (Albany, Buffalo, Rochester, Syracuse, Utica/Watertown), we used a blend of the currently approved rating region factors for our current GHI Small Group products.

PEPM to Individual rate conversion factor and Family Rate tiers
We have mapped the membership from GHI's current product portfolio as a basis to project the expected membership distribution for the small group Products as shown in **Appendix R** to calculate the single conversion factor of **1.206.**

Quarterly Step up Factors
Premium rates for 2Q14, 3Q14 and 4Q14 have been developed using the annual trend rates described previously plus the impact of changes in the ACA fees. The derivation of the **3.1%** quarterly step ups are shown in **Appendix R-1.**

A premium rate manual has been included which conforms to the New York State's standardized census tiers

Age 29 Rider
All metal level plans include an optional age 29 rider which extend coverage to unmarried, uninsured adult children up through age 29. The age 29 rider was priced using the adjustment factor of **2.1**% as shown in **Appendix T.** The current 4.0% Age 30 factor shown in Exhibit T is the current approved Age 30 factor for GHI's 4-tier Small Group business.

Domestic Partner Rider
GHI will be providing domestic partner coverage at no additional cost.

Pediatric Dental
Pediatric dental will not be offered as an embedded benefit in GHI's off exchange product portfolio and rates for pediatric coverage are not included in the premium rate manual. We are in the process of arranging a contract with Dentcare Delivery Systems to provide stand-alone pediatric benefits to our members.

Loss Ratio

The requested premium rates result in an **88.2**% target loss ratio based on the above assumptions.

Standard Exhibits

Please note the following regarding the following standardized exhibits:

- Exhibit 7: All GHI small group products in the experience period of 4Q2011-3Q2012 are shown. As discussed in the "Expected Member Mix" section above, we used current member mix as the starting point to determine our projected "Exchange" member mix.

- Exhibit 8: Please note the following regarding Exhibit 8:
  - Please note the CLA, ACA Fees, and Administrative costs are not shown in Exhibit 8. These are shown in Appendix P. Line # 42 of Exhibit 8 corresponds to row 39 of Appendix P.
  - Pricing Actuarial Values:
    - In Appendix P, we apply the following adjustments:
      - Index Rate calculation
        - Row 13 shows current Pricing AV for the Experience Period **(0.7778)**
        - Row 14 shows expected Pricing AV for the small group Market **(0.6185)**
        - Row 15 shows the ratio of Row 14 / Row 13 **(0.7952** = **0.6185/0.7778)**. This reduced the paid claim cost in the Index rate to reflect the higher cost sharing anticipated in the Exchange.
      - Plan specific calculation
        - Row 29 is the plan-specific Pricing AV calculated for each plan (e.g., **0.6185** for Bronze)
        - Row 30 is the expected Pricing AV for the small group Market **(0.6185**)
        - Row 31 is the ratio of Row 30 / Row 29 (e.g., **1.0000 = 0.6185/0.6185**)
    - In Exhibit 8:
      - Line # 11 corresponds to Row 13 of Appendix P
      - Line # 26 corresponds to Row 14 of Appendix P
      - Line # 28 corresponds to Row 29 of Appendix P
      - Line # 39 corresponds to Row 30 of Appendix P
  - Line 10B corresponds to the Member Months from Exhibit 7. As discussed above and summarized in **Appendix H-1**, the initial projected claims cost for Off-Exchange membership was based on existing membership, and then adjusted for expected "Off-Exchange" member mix.
  - **Appendix S** shows how the $**338.23** PMPM in Line # 10C was derived based on the $**449.28** PMPM in row 1 of **Appendix P**. In essence, this represents untrended base experience adjusted for certain items shown in Appendix P.

- Exhibit 9: A comparison of the ACA Fees and Administrative expenses in Exhibit 9 to the ACA Fees and Administrative expenses in Exhibit 2 of GHI's 2013 Small Group's Prior Approval filing is as follows:
  - 332 Assessments, etc.: Assumed **0.95**% in both filings

- Administrative expenses that improve HC quality: Note that in the 2013 Prior Approval filing, this was classified as a "claims" expense when calculating our premium rate. The **0.70**% used for the 2014 Off-Exchange filing
- Commissions: We have recently filed for a 0% commission rate on our small group products which will apply to our new 2014 products. We assumed **6.0%** were paid in our 2013 Small Group Prior Approval filing.
- Other federal fees and assessments: This increased from **0.3%** for 1Q2013 to **2.68%** due to the new ACA fees described above that will become effective in 2014.
- Other administrative expenses: This was reduced from **7.77**% in the 2013 Prior Approval filing to **6.5**% in the 2014 Off Exchange filing.

Uniform Rate Review Template

Worksheet 1 of the Unified Rate Review Template (URRT): Worksheet 1 does not demonstrate the process used to develop the rates. It represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The Experience Period in the URRT contains incurred 2012 claims. These claims were derived from allowed claims, incurred from October 2011 through September 2012 paid through December 2012 (plus appropriate completion factors), trended forward 3 months. Trend, market wide factors and expense loads as previously described in this actuarial memorandum were applied to the experience period claims to project 2014 experience. Note that these factors have been adjusted to reflect the differences in URRT base period data.

As previously stated, this exhibit provides information required by Federal regulation and does not demonstrate the process to develop rates.

Actuarial Certification

I am a Member of the Society of Actuaries and member of the American Academy of Actuaries; and meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.

I further certify that to the best of my knowledge:

1. This filing, including the projected index rate, is in compliance with all applicable New York State and Federal laws and regulations (45 CFR 156.80(d)(1)).
2. The filing is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
    - ASOP No. 5, Incurred Health and Disability Claims
    - ASOP No. 8, Regulatory Filings for Health Plan Entities
    - ASOP No. 12, Risk Classification
    - ASOP No. 23, Data Quality

- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 41, Actuarial Communications

3. The expected loss ratio incorporated into the proposed rate tables meets the minimum requirement of the State of New York.
4. The benefits are reasonable in relation to the premiums charged.
5. The rates are not unfairly discriminatory.
6. Only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
7. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans with one adjustment for outpatient copays as described above in the Actuarial Memorandum. The adjustment was developed in accordance with generally accepted actuarial principles and methodologies.

Please keep all information contained in this rate filing confidential.

[redacted]

[redacted]
Senior Actuary, EmblemHealth Actuarial Services
[redacted]
May 30, 2013

Data Collection Template

Company Legal Name: **GHI** State: **NY**
HIOS Issuer ID: **88000** Market: **Small Group**
Effective Date of Rate Change(s): **01/01/2014**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 01/01/2012 to 12/31/2012

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$519,910,259	$388.21	100.00%
Incurred Claims in Experience Period	$502,370,730	375.12	96.63%
Allowed Claims:	$581,874,789	434.48	111.92%
Index Rate of Experience Period		$0.00	
Experience Period Member Months	1,339,233		

Section II: Allowed Claims, PMPM basis

	Experience Period on Actual Experience Allowed				Projection Period: 01/01/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 24 months									
					Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Visits	64.17	$20,714.91	$110.78	1.000	1.000	1.137	1.010	65.46	$26,769.15	$146.04	0.00	$0.00	$0.00
Outpatient Hospital	Visits	679.64	$1,401.69	79.39	1.000	1.000	1.135	1.040	735.10	1,806.94	110.69	0.00	0.00	0.00
Professional	Visits	9,951.67	$182.99	151.75	1.000	1.000	1.077	1.020	10,353.72	212.37	183.24	0.00	0.00	0.00
Other Medical	Other	12,000.00	6.75	6.75	1.000	1.000	1.020	1.000	12,000.00	7.02	7.02	0.00	0.00	0.00
Capitation	Other	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	0.00	0.00	0.00
Prescription Drug	Prescriptions	9,824.54	$93.91	76.89	1.000	1.000	1.090	1.020	10,221.45	111.51	94.98	0.00	0.00	0.00
Total				$425.56							$541.97			$0.00

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	100.00%	0.00%	$541.97	$290,561,431
Paid to Allowed Average Factor in Projection Period			0.619	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$335.22	$179,720,729
Projected Risk Adjustments PMPM			62.72	33,627,108
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$272.50	$146,093,621
Projected ACA reinsurance recoveries, net of rein prem, PMPM			0.00	0
Projected Incurred Claims			$272.50	$146,093,621
Administrative Expense Load		8.15%	25.31	13,570,966
Profit & Risk Load		1.00%	3.11	1,665,855
Taxes & Fees		3.15%	9.80	5,255,019
Single Risk Pool Gross Premium Avg. Rate, PMPM			$310.72	$166,585,461
Index Rate for Projection Period			$ 404.55	
% increase over Experience Period			-19.96%	
% Increase, annualized:			-10.54%	
Projected Member Months				536,124

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name: **GHI** State: **NY**
HIOS Issuer ID: **88000** Market: **Small Group**
Effective Date of Rate Change(s): **01/01/2014**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		CDHP EPO	CDHP PPO	EPO Share	GHI-EPO	GHI-PPO	HCTC	SBAP	GHI Bronze
Product ID:		88000NY006	88000NY005	88000NY004	88000NY002	88000NY001	88000NY019	88000NY007	88000NY026
Metal:		Bronze	Silver	Gold	Gold	Platinum	Platinum	Gold	Bronze
AV Metal Value		0.666	0.716	0.786	0.831	0.855	0.893	0.808	0.582
AV Pricing Value		0.710	0.764	0.838	0.886	0.912	0.952	0.862	0.619
Plan Type:		EPO	PPO	EPO	EPO	PPO	EPO	PPO	EPO
Plan Name		CDHP EPO	CDHP PPO	EPO Share	GHI-EPO	GHI-PPO	HCTC	SBAP	EmblemHealth Tri-State EPO HD6300
Plan ID (Standard Component ID):		88000NY0060001	88000NY0050001	88000NY0040001	88000NY0020001	88000NY0010001	88000NY0190001	88000NY0070001	88000NY0260001
Exchange Plan?		No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2		29.31%	31.16%	20.39%	19.67%	21.74%	16.31%	17.70%	0.00%
Historical Rate Increase - Calendar Year - 1		13.10%	13.56%	13.39%	13.20%	13.63%	12.34%	12.34%	0.00%
Historical Rate Increase - Calendar Year 0		12.65%	12.65%	11.52%	11.50%	11.26%	11.34%	11.34%	0.00%
Effective Date of Proposed Rates		01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014
Rate Change % (over prior filing)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		12.65%	12.65%	11.52%	11.50%	11.26%	11.34%	11.34%	0.00%
Proj'd Per Rate Change % (over Exper. Period)		12.65%	12.65%	11.52%	11.50%	11.26%	11.34%	11.34%	#DIV/0!
Product Threshold Rate Increase %		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	88000NY0060001	88000NY0050001	88000NY0040001	88000NY0020001	88000NY0010001	88000NY0190001	88000NY0070001	88000NY0260001
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$0.00	$312.34	$399.89	$387.68	$463.64	$842.98	$1,031.34	$822.07	$0.00
Projected Member Months	536,124	0	0	0	0	0	0	0	536,124

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	88000NY0060001	88000NY0050001	88000NY0040001	88000NY0020001	88000NY0010001	88000NY0190001	88000NY0070001	88000NY0260001
Average Rate PMPM	$388.21	$277.26	$354.98	$347.63	$415.81	$757.69	$926.32	$738.36	$0.00
Member Months	1,339,233	221,278	59,285	279,039	731,680	41,218	359	6,374	0
Total Premium (TP)	$519,910,259	$61,351,444	$21,045,020	$97,003,504	$304,240,826	$31,230,631	$332,548	$4,706,284	$0
EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$581,874,473	$90,071,760	$33,803,086	$99,417,928	$319,041,676	$34,719,820	$122,871	$4,697,332	$0
EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation:	$79,504,060	$22,483,955	$6,417,169	$16,583,325	$29,621,936	$3,821,068	$15,763	$560,844	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0							
Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%							
Total Incurred claims, payable with issuer funds	$502,370,414	$67,587,805	$27,385,917	$82,834,603	$289,419,740	$30,898,752	$107,108	$4,136,488	$0
Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Incurred Claims PMPM	$375.12	$305.44	$461.94	$296.86	$395.56	$749.64	$298.35	$648.96	#DIV/0!
Allowed Claims PMPM	$434.48	$407.05	$570.18	$356.29	$436.04	$842.35	$342.26	$736.95	#DIV/0!
EHB portion of Allowed Claims, PMPM	$434.48	$407.05	$570.18	$356.29	$436.04	$842.35	$342.26	$736.95	#DIV/0!

:tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	88000NY0060001	88000NY0050001	88000NY0040001	88000NY0020001	88000NY0010001	88000NY0190001	88000NY0070001	88000NY0260001
Average Rate PMPM	$0.00	$312.34	$399.89	$387.68	$463.64	$842.98	$1,031.34	$822.07	$0.00
Member Months	536,124	-	-	-	-	-	-	-	536,124
Total Premium (TP)	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHB basis or full portion of TP, [see instructions]	#DIV/0!	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$290,561,431	$0	$0	$0	$0	$0	$0	$0	$290,561,431
EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	$110,840,701	$0	$0	$0	$0	$0	$0	$0	$110,840,701
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0							
insured person, as %	0.00%	#DIV/0!							
Total Incurred claims, payable with issuer funds	$179,720,729	$0	$0	$0	$0	$0	$0	$0	$179,720,729
Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Amt of Risk Adj	$33,627,108	$0	$0	$0	$0	$0	$0	$0	$33,627,108

Incurred Claims PMPM	$335.22	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$335.22
Allowed Claims PMPM	$541.97	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$541.97
EHB portion of Allowed Claims, PMPM	$541.97	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$541.97

Appendix A
GHI

Metal Level	Standard Plan / Non Standard Plan	Product Name	On Exchange	Metal AV Value
		Individual Off Exchange Plan		
Bronze	Non-Standard	EmblemHealth Tri-State EPO HD6300[d]	Off Exchange	0.582
		Small Group Off Exchange Plan		
Bronze	Non-Standard	EmblemHealth Tri-State EPO HD6300	Off Exchange	0.582

OFF EXCHANGE: Underwritten: GHI	Bronze
Product Type:	**EPO**
Ind/Fam Deductible (Med/Hosp/Vision/Rx)	$6,300/$12,600 (per cal/yr.)
Ind/Fam Maximum OOP (incl Ded):	$6,300/$12,600
Rx included in Deductible:	Yes
Rx included in OOP maximum:	Yes
Q4 Deductible Carry Over	No
PCP Visit (injury or illness)	0% cost sharing per visit
Specialist Visit	0% cost sharing per visit
Inpatient Facility/SNF/Hospice	0% cost sharingper admission
Outpatient Facility - Surgery, including free-standing surgicenters	0% cost sharing per visit
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	0% cost sharing per visit
Emergency Room - Facility charge (INN/ONN)	0% cost sharing (waived if admitted as an inpatient)
Emergency room visit - Physician charge	0% cost sharing per visit
Urgent Care (INN)	0% cost sharing per visit
Observation Stay	0% cost sharing (waived if admitted as inpatient)
Anesthesia	0% cost sharing
Emergent Ambulance	0% cost sharing per visit
Non-Emergent Ambulance Hosp to Facility Transfer	Covered in Full
PT/OT/ST (Rehabilitative & Habilatative)	0% cost sharing per visit
DME/Medical Supplies	0% Coinsurance
Hearing Aids	0% Coinsurance
Eyewear	0% Coinsurance
Exercise Facility Reimbursement	**Subscriber reimbursed at the lesser of $200 or actual cost of membership per six-month period and 50 visits. Subscriber's spouse reimbursed at the lesser of $100 or actual cost of membership per six-month period and 50 visits.** *** Incentive not applied to OOP or Deductible**

SERVICE	LIMIT/Note	IP Fac	OP Fac	Prof
Outpatient Services				
PCP Office Visits (Injury or Illness)	No Limit	N/A	N/A	0% Cost Sharing
Specialist Visits	No Limit	N/A	N/A	0% Cost Sharing
Outpatient Facility or Ambulatory Surgery	No Limit	N/A	OP Fac cost sharing on surgeries done in AmSurg or OP Facility.	N/A
Outpatient Surgery Physician/Surgical Services	No Limit	N/A	N/A	Surgeon 0% Cost Sharing
Outpatient Diagnostic and Routine Laboratory/Pathology/Routine Imaging (X-rays)/Imaging (CAT/PET/MRI)	No Limit	N/A	0% Cost Sharing	N/A
Radiation Therapy	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Home Health Care Services	Coverage is limited to 60 visits per calendar year.	N/A	0% Cost Sharing	0% Cost Sharing
Hemodialysis/Renal dialysis	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Out of Network Dialysis	Limit is 10 visits. Coverage for out of network provider on an in-network basis if member is traveling outside the service area.	N/A	0% Cost Sharing	0% Cost Sharing
Chemotherapy	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Preadmission Testing	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Autologous Blood Banking	Only in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury.	N/A	0% Cost Sharing	N/A
Outpatient Rehabilitation Services/Habilitation Services (PT, OT, ST)	ST: 60 vists per calendar year OT/PT: 120 visits per calendar year	N/A	0% Cost Sharing	0% Cost Sharing
Chiropractic Care	No Limit	N/A	N/A	0% Cost Sharing
Durable Medical Equipment	**Coverage for standard equipment only. DME defined as Equipment which is 1). Designed and intended for repeated use, 2), primarily and customarily used to serve a medical purpose, 3). Generally not useful to person in the absence of disease or injury, and 4) is appropriate for use in the home. Orthotics are excluded * See Model Language	N/A	N/A	0% coinsurance
Prosthetic Devices - External	2 external prosthetic device per lifetime *Coverage for external repairs or replacement in adults. - Coverage for wigs made from human hair if member is allergic to synthetic wig materials. To determine if this can be configured **Additional coverage for external device replacement for children for devices that have been outgrown - Coverage includes wigs for members suffering from severe hair loss due to injury or disease or treatment of a disease (e.g. chemotherapy)	N/A	N/A	0% coinsurance (for devices)
Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Infertility Treatment	Unlimited / Member must be between ages of 21 and 44 * Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy. Includes correctable medical conditions leading to infertility ** Advanced infertility is not covered	N/A	OP Fac cost sharing on surgeries done in AmSurg or OP Facility.	Surgeon 50 %Cost Sharing
Infertility Treatment	Provider visits and non surgical services under infertility treatment	N/A	0% Cost Sharing	0% Cost Sharing
Termination of Pregnancy	Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules	N/A	OP Amb Surgery Cost Sharing	Surgeon 0% Cost Sharing

Elective Termination of Pregnancy	One per calendar year Limit Interruption of Pregnancy Elective abortions limited to one procedure per member per calendar year * Therapeutic termination of pregnancy unlimited. Note follows current rules ****(to discuss configuration of therapeutic vs elective; re: limits and differentiating via specific codes on claims - with Med Mgmt and Claims)	N/A	OP Amb Surgery Cost Sharing	Surgeon 0% Cost Sharing
Diabetic supplies	No Limit	N/A	N/A	0% Cost Sharing / 30 day supply
Diabetic drugs (including insulin)	No Limit	N/A	N/A	0% Cost Sharing / 30 day supply
Diabetic education and self-management	No Limit	N/A	N/A	0% Cost Sharing
Allergy testing and treatment; Allergy shots	No Limit	N/A	N/A	0% Cost Sharing
ABA treatment for Autism Spectrum Disorder	Actuarial equivalence to 680 hours per year annual ABA limit	N/A	N/A	0% Cost Sharing
Assistive Communication Devices for Autism Spectrum Disorder		N/A	N/A	0% Cost Sharing per device
Emergency Services		**IP Fac**	**OP Fac**	**Prof**
Emergency Room Services	No Limit. Copay waived if admitted as IP	N/A	0% Cost Sharing	0% Cost Sharing
Observation Stay	Copay waived if admitted as IP Note: If ER and Obs. Stay, only one copay.	N/A	0% Cost Sharing	N/A
Urgent Care Centers or Facilities	INN Coverage Only	N/A	0% Cost Sharing	Urgent Care 0% Cost sharing for "freestanding" Urgent Care (e.g., "doc in a box"). 0% cost sharing for Urgent Care physicians
Emergency Transportation/Ambulance	No Limit Covers Land, Air and Water	0% Cost Sharing		
Non Emergent Transportation/Ambulance	No Limit (Hospital to Facility transfer only) Land and Air only; Ambulette is excluded.	Covered in Full		
Hospitalization		**IP Fac**	**OP Fac**	**Prof**
Inpatient Hospital Services	No Limit*	0% Cost Sharing	N/A	N/A
Inpatient Physician and Surgical Services	No Limit	N/A	N/A	Surgeon cost sharing on surgeon claim. $0 cost sharing on all other IP professional svcs
Skilled Nursing Facility	Skilled Nursing limited to 200 days per calendar year*	0% Cost Sharing	N/A	$0 cost sharing on all SNF professional services
Delivery and all Inpatient Services for Maternity Care	No Limit (covers mother and newborn combined)*	0% Cost Sharing	N/A	Surgeon cost sharing on maternity delivery. Only one copay per pregnancy (e.g., covers delivery and post-natal svcs.)
Inpatient Rehabilitation Services	Inpatient rehabilitation therapy is covered for consecutive 60-day period, for physical, speech and occupational therapies when hospitalization would otherwise be necessary and the member must require skilled care on a daily basis, which is not primarily custodial and can only be provided on an inpatient basis. Admission must begin within six(6) months inpatient hospital stay or outpatient surgical procedure Copay not taken if member readmitted w/in 90 days for same or related condition. **Cardiac and Pulmonary Rehab is not covered.**	0% Cost Sharing	N/A	$0 cost sharing for any professional svcs associated with IP admission
Bariatric Surgery	No Limit*	0% Cost Sharing	0% Cost Sharing	Surgeon 0% Cost Sharing. $0 cost sharing on all other IP professional svcs
Mental Health and Substance Abuse Disorder Services		**IP Fac**	**OP Fac**	**Prof**
Mental/Behavioral Health Outpatient Services	No Limit Includes 20 OP visits for family counseling are covered.	N/A	0% Cost Sharing	0% Cost Sharing
Mental/Behavioral Health Inpatient Services	No Limit*	0% Cost Sharing	N/A	$0 cost sharing for any professional svcs associated with IP admission
Substance Abuse Disorder Outpatient Services	No Limit	N/A	0% Cost Sharing	0% Cost Sharing
Substance Abuse Disorder Inpatient Services	No Limit*	0% Cost Sharing	N/A	$0 cost sharing for any professional svcs associated with IP admission
Laboratory and Imaging Services		**IP Fac**	**OP Fac**	**Prof**
Diagnostic Test (X-Ray and Lab Work)	No Limit Note: only 1 copay applies and does not apply of claims for X-ray interpretation.	N/A	0% Cost Sharing	0% Cost Sharing
Imaging (CT/PET Scans, MRI)	No Limit Note: This does not apply to claims for interpretation of imaging	N/A	0% Cost Sharing	0% Cost Sharing
Preventive and Wellness Services		**IP Fac**	**OP Fac**	**Prof**
Preventive Care/Screening/Immunization	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. $0 cost sharing for ACA preventive svcs and other $0 cost sharing NYS mandates.	N/A	Covered in Full	Covered in Full
Prenatal and Postnatal Care	No Limit - Covered in Full	N/A	Covered in Full	Covered in Full
Pediatric Vision		**IP Fac**	**OP Fac**	**Prof**
Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	One exam per 12 month period. Up to age 19 end of month.	N/A	N/A	0% Cost Sharing
Prescription Lenses	Must provide coverage for eye exam, lenses and frames (once in any 12 month period) and contact lenses (only when deemed medically necessary)	N/A	N/A	0% coinsurance applies to combined cost of lenses and frames
Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation.	N/A	N/A	0% coinsurance applies to combined cost of lenses and frames
Contact Lenses	in lieu of frames	N/A	N/A	0% coinsurance

Other Services		IP Fac	OP Fac	Prof
Hospice Services (includes End of Life Care)	210 days/year; also includes 5 Bereavement Counseling sessions for members family either before or after the death of the member. For End of Life Care - Non-Par providers are covered. ** Refer to model language for rules	0% Cost Sharing	0% Cost Sharing	0% Cost Sharing
Family Planning - Contraceptive drugs and devices, tubal ligations	No Limit * Women's Wellness mandate	N/A	N/A	Covered in Full
Vasectomies-Office		N/A	N/A	0% Cost Sharing
Vasectomies-Outpatient/ Amb Surgery		N/A	0% Cost Sharing	Surgeon 0% Cost Sharing
Hearing Evaluations/testing	No Limit	N/A	N/A	0% Cost Sharing
Hearing Aids	Limited to a single purchase for one or both ears (including repair/replacement) every three years.	N/A	N/A	0% Cost Sharing
Outpatient Cardiac and Pulmonary Therapy	No limits in Model Language.	N/A	0% Cost Sharing	0% Cost Sharing
Second Opinion (surgical)	Second surgical opinion on the need for surgery.	N/A	N/A	0% Cost Sharing
Second Opinion (Specialist - cancer)	Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer. Copay applies to Par and Non Par	N/A	N/A	0% Cost Sharing
Transplants	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition * Solely for transplants for surgeries determined to be non-experimental and non-investigational.	0% Cost Sharing	N/A	Surgeon 0% Cost Sharing. $0 cost sharing on all other IP professional svcs
Oral Surgery	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition. * Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery *Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.	0% Cost Sharing	N/A	Surgeon 0% Cost Sharing. $0 cost sharing on all other IP professional svcs.
Oral Surgery	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition. * Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery *Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.	N/A	0% Cost Sharing	Surgeon 0% Cost Sharing
Oral Surgery	No Limit/ Copay not taken if member readmitted w/in 90 days for same or related condition. * Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairment and surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery *Oral Surgery Coverage must be provided for Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.	N/A	N/A	0% Cost Sharing
Infusion Therapy		N/A	N/A	0% Cost Sharing
Infusion Therapy	No limit	N/A	0% Cost Sharing	0% Cost Sharing
Anesthesia (all settings)	No limit	0% Cost Sharing	0% Cost Sharing	0% Cost Sharing
Prescription Drugs		**IP Fac**	**OP Fac**	**Prof**
Enteral Formulas	No Limit Note: Follows current practice for MM and Pharmacy	N/A	N/A	N/A
Retail: Tier 1/Generic: Tier 2/Formulary Brand Tier 3/Non-Formulary *Mail Order up to 90 day supply: 2.5x the 30 day supply cost sharing	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Specialty Drugs	30 day supply *Mail Order up to a 90 day supply optional benefit	N/A	N/A	N/A
Off Label Cancer Drugs	30 day supply	N/A	N/A	N/A

(1) Pediatric Dental removed since standalone

Appendix C

User Inputs for Plan Parameters

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

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

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$6,300.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$6,300.00
OOP Maximum if Separate ($)			

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

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

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.16369%
Metal Tier:	Bronze

Appendix D

Quality Improvement and Cost Containment Programs

Expense Type	Detailed Description of Expense
1. Improve Health Outcomes	
A. Disease Management	Expenses related to providing – Rare Disease Management with unlimited access to specialty nurses, Disease specific and personalized health assessments, On going monitoring and care coordination, Collaboration with Member's personal physician and care team, Disease-specific information, educational brochures and quarterly news letters. Education, health support and disease management services to reduce limb amputations and hospitalizations and improve outcomes for members in poorest health with Diabetes as well as Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Asthma or chronic obstructive pulmonary disease (COPD) as co morbid conditions. Enhance the quality of life for members with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) and educate them on options such as kidney transplantation. Members may receive educational materials, HRA and telephonic nurse support. Emblem's Positive Action Toward Health (PATH) program which provides an opportunity to work one on one with a professional nurse health coach by telephone, who provides counseling to elicit change in behavior; Educational materials about symptom management, health risks and treatment for members with asthma, diabetes, CHF, COPD and CAD.
B. Case Management	Expenses related to providing – A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes Case Management Nursing model that supports members with a focus on the home based fragile members with multiple conditions and several needs. Behavioral Health case and disease management services to members with depression, severe psychiatric conditions and multiple hospitalizations. Management of members with CHF by providing information to member's doctors through in home monitoring devices and nurse monitoring services.
C. Late Stage Cancer Program	This program lends support, guidance and education to members with late stage cancer, their caregivers and family during critical times of cancer care.
D. Interactive Voice Response based calling	Phone calls to members in support of various HEDIS and QARR initiatives.
E. Quality Improvement Committee Physician Fees	Physicians are paid to be part of a committee to review and provide feedback on the Company's quality improvement strategies and to review and provide input on quality of care complaints received.
F. New member surveys and health risk assessments	In order to determine the health status of new members and identify needs for complex case management and disease management programs, surveys and health risk assessments are performed on new members.
G. Patient satisfaction surveys	These surveys serve as a consumer assessment of healthcare providers and systems. The results are used to assess the patient-centeredness of care, compare and report on performance and improve the quality of care.
2. Activities to prevent Hospital Readmissions.	
End of Life/Palliative Care	This program is targeted at members with advanced/terminal illness no longer seeking curative treatment and helps members and family transition to end of life care.
4. Wellness and Health Promotion Activities	

Quality Improvement and Cost Containment Programs

Healthy Beginnings	The Healthy Beginnings Program provides incentives for expecting moms if they get post partum check up and complete a post partum depression surveys. It also provides health risk assessments, access to a 24 hour babyline staffed by nurses and stratification and education materials to members.
Weight Watchers	The Company subsidizes the Weight Watchers membership fees of our members.
Healthy Roads	This program provides coaching for weight management, physical activity and stress.
Arthritis Classes	Classes are provided to members and teaches them exercises that make them stronger, increase flexibility and reduce pain.
Smoking Cessation Programs	A tobacco free program in partnership with the American Cancer Society.
Biometrics Screenings	Biometrics screenings provided to members.
Flu Vaccines	Flu Vaccines provided to members.
Member Health and Fitness	Fitness facility for members and incentives for members who participate in health and wellness programs.
Neighborhood Care " Care Cafes "	The Neighborhood Care Program was established with the vision to improve health care and health status in the neighborhoods by implementing a new community based utility infrastructure in two New York City neighborhoods. The Neighborhood Care concept is based on the "consumer retail" model, in which plan members are invited to visit the Neighborhood Care store in person for insurance and health issue resolutions. The Neighborhood Care Program houses both a customer service team and a clinical team. The service team is staffed by customer service employees whose main role is to address a broad spectrum of member needs such as administrative issue resolution, benefit education, physician referral assistance and plan enrollment. The clinical team consists of a multidisciplinary clinically-based team that includes a registered nurse, a social worker, two care navigators, and a pharmacist. In addition, each Neighborhood Care site has a site manager and a community liaison, whose responsibility is to act as the link between the community, Neighborhood Care, and EmblemHealth.
5. HIT Expenses for Health Care Quality Improvement	
A. Disease and Case Management software	Software license and maintenance expense for applications that support Disease and Case management programs.
B. HIT expenses in support of HEDIS	Hosting, data mapping and software license fees associated with HEDIS reporting initiatives.
C. Wellness and Health Promotion electronic tools	Expenses for member website tools such as personal health records, health risk assessments, self-guided Action Plans. The health risk assessment and personal health records provide triggered messaging related to disease management, weight loss and reminders for medical exams.
D. Treatment cost calculators	Web based tool that provides members with treatment choices and cost estimates for nearly 300 common treatments.
E. Data analysis tools	Tools used improve the effectiveness of case management by identifying gaps in care and identifying high impact populations.
F. Preauthorization and referral system	This system enables and expedites the referral and authorization process to direct appropriate care.
G. Data Warehouse	Warehouses used to house all clinical information used for disease management. This includes the cost of integrating data from third party administrators.
H. ICD-10 Expenses (International Classification of Diseases)	Insurance Portability and Accountability Act, limited to .3 percent of an issuer's earned premium as defined by the guidance. Expenses in excess of the .3 percent of premium including all maintenance costs will be excluded from QI expenses and reported as other claim adjustment expenses.

Exhibit E

GHI-EPO

Rate Ratio		
Year	Quarter	Rate Ratio
2010	Q1	1.668
2010	Q2	1.544
2010	Q3	1.479
2010	Q4	1.378
2011	Q1	1.379
2011	Q2	1.324
2011	Q3	1.288
2011	Q4	1.249

Renewal Distribution			
Renewal Month	Premium Before Renewal	Premium After Renewal	Premium Total
JAN	$0	$31,331,998	$31,331,998
FEB	$2,122,802	$23,626,291	$25,749,093
MAR	$6,380,396	$36,624,291	$43,004,687
APR	$4,948,759	$15,235,533	$20,184,292
MAY	$5,831,224	$12,891,449	$18,722,673
JUNE	$12,754,500	$18,842,642	$31,597,142
JUL	$11,005,374	$9,219,320	$20,224,694
AUG	$11,614,608	$8,445,524	$20,060,132
SEP	$17,691,641	$8,833,237	$26,524,878
OCT	$11,520,839	$3,821,014	$15,341,853
NOV	$14,807,443	$2,984,973	$17,792,416
DEC	$25,877,736	$2,678,442	$28,556,178
Total			**$299,090,037**

2011 Rate Ratios By Renewal Month	
Jan	1.379
Feb	1.402
Mar	1.421
Apr	1.378
May	1.393
Jun	1.413
Jul	1.392
Aug	1.398
Sep	1.415
Oct	1.346
Nov	1.356
Dec	1.366
Average 2011 Rate Ratio	**1.393**

Standardized Premium	
Earned Premium PMPM	$387.24
Average Rate Ratio	1.393
Standardized Premium PMPM	$539.26

Appendix F
GHI's Medical Trend Factors

		CY 2012								CY 2013								CY 2014							
LOB	Product	Contracted Cost	Utiliza-tion	Cost Share Leverage	Risc Score	Provider Mix	Total Cost	Total Utilization	Theoretical PMPM Trend	Contracted Cost	Utiliza-tion	Cost Share Leverage	Risc Score	Provider Mix	Total Cost	Total Utilization	Theoretical PMPM Trend	Contracted Cost	Utiliza-tion	Cost Share Leverage	Risc Score	Provider Mix	Total Cost	Total Utilization	Theoretical PMPM Trend
Inpatient Facility																									
SG	GHI-PPO	8.9%	1.0%	0.5%	9.0%	0.8%	9.8%	10.1%	21.5%	7.1%	1.0%	0.5%	6.0%	0.8%	8.5%	7.1%	16.2%	7.1%	1.0%	0.5%	6.0%	0.8%	8.0%	7.1%	16.2%
SG	GHI-EPO	8.8%	1.0%	0.5%	4.5%	0.8%	9.7%	5.5%	16.3%	7.1%	1.0%	0.5%	3.0%	0.8%	8.5%	4.0%	12.9%	7.1%	1.0%	0.5%	3.0%	0.8%	8.0%	4.0%	12.9%
SG	EPO Share	9.0%	1.0%	1.0%	3.0%	0.8%	9.9%	4.0%	15.4%	7.1%	1.0%	1.0%	2.0%	0.8%	9.0%	3.0%	12.3%	7.1%	1.0%	1.0%	2.0%	0.8%	8.0%	3.0%	12.3%
SG	CDHP EPO	8.8%	1.0%	5.0%	4.7%	0.8%	9.7%	5.7%	21.8%	7.1%	1.0%	5.0%	3.1%	0.8%	13.4%	4.2%	18.1%	7.1%	1.0%	5.0%	3.1%	0.8%	8.0%	4.2%	18.1%
SG	CDHP PPO	8.7%	1.0%	2.5%	9.0%	0.8%	9.6%	10.1%	23.6%	7.1%	1.0%	2.5%	6.0%	0.8%	10.7%	7.1%	18.5%	7.1%	1.0%	2.5%	6.0%	0.8%	8.0%	7.1%	18.5%
SG	SBAP	8.1%	1.0%	0.5%	9.0%	0.8%	9.0%	10.1%	20.6%	7.1%	1.0%	0.5%	6.0%	0.8%	8.5%	7.1%	16.2%	7.1%	1.0%	0.5%	6.0%	0.8%	8.0%	7.1%	16.2%
SG	HCTC	7.0%	1.0%	1.0%	4.5%	0.8%	7.9%	5.5%	15.0%	7.1%	1.0%	1.0%	3.0%	0.8%	9.0%	4.0%	13.4%	7.1%	1.0%	1.0%	3.0%	0.8%	8.0%	4.0%	13.4%
DP	DP Core	8.8%	1.0%	2.5%	2.2%	0.8%	9.7%	3.2%	16.0%	7.1%	1.0%	2.5%	2.2%	0.8%	10.7%	3.2%	14.2%	7.1%	1.0%	2.5%	2.2%	0.8%	8.0%	3.2%	14.2%
DP	DP Value	8.0%	1.0%	2.5%	2.2%	0.8%	8.9%	3.2%	15.2%	7.1%	1.0%	2.5%	2.2%	0.8%	10.7%	3.2%	14.2%	7.1%	1.0%	2.5%	2.2%	0.8%	8.0%	3.2%	14.2%
HNY	HNY EPO	7.9%	1.0%	1.0%	2.2%	0.8%	8.8%	3.2%	13.4%	7.1%	1.0%	1.0%	2.2%	0.8%	9.0%	3.2%	12.5%	7.1%	1.0%	1.0%	2.2%	0.8%	8.0%	3.2%	12.5%
Outpatient Facility																									
SG	GHI-PPO	8.6%	4.0%	0.5%	9.0%	0.8%	9.5%	13.4%	24.7%	7.2%	4.0%	0.5%	6.0%	0.8%	8.6%	10.2%	19.7%	7.2%	4.0%	0.5%	6.0%	0.8%	8.1%	10.2%	19.7%
SG	GHI-EPO	8.6%	4.0%	0.5%	4.5%	0.8%	9.5%	8.7%	19.6%	7.2%	4.0%	0.5%	3.0%	0.8%	8.6%	7.1%	16.3%	7.2%	4.0%	0.5%	3.0%	0.8%	8.1%	7.1%	16.3%
SG	EPO Share	8.2%	4.0%	1.0%	3.0%	0.8%	9.1%	7.1%	18.0%	7.2%	4.0%	1.0%	2.0%	0.8%	9.1%	6.1%	15.8%	7.2%	4.0%	1.0%	2.0%	0.8%	8.1%	6.1%	15.8%
SG	CDHP EPO	8.4%	4.0%	5.0%	4.7%	0.8%	9.3%	8.9%	24.9%	7.2%	4.0%	5.0%	3.1%	0.8%	13.5%	7.3%	21.7%	7.2%	4.0%	5.0%	3.1%	0.8%	8.1%	7.3%	21.7%
SG	CDHP PPO	8.7%	4.0%	2.5%	9.0%	0.8%	9.6%	13.4%	27.3%	7.2%	4.0%	2.5%	6.0%	0.8%	10.8%	10.2%	22.1%	7.2%	4.0%	2.5%	6.0%	0.8%	8.1%	10.2%	22.1%
SG	SBAP	9.1%	4.0%	0.5%	9.0%	0.8%	10.0%	13.4%	25.3%	7.2%	4.0%	0.5%	6.0%	0.8%	8.6%	10.2%	19.7%	7.2%	4.0%	0.5%	6.0%	0.8%	8.1%	10.2%	19.7%
SG	HCTC	7.2%	4.0%	0.5%	4.5%	0.8%	8.1%	8.7%	18.0%	7.2%	4.0%	0.5%	3.0%	0.8%	8.6%	7.1%	16.3%	7.2%	4.0%	0.5%	3.0%	0.8%	8.1%	7.1%	16.3%
DP	DP Core	8.7%	4.0%	2.5%	2.2%	0.8%	9.6%	6.3%	19.4%	7.2%	4.0%	2.5%	2.2%	0.8%	10.8%	6.3%	17.7%	7.2%	4.0%	2.5%	2.2%	0.8%	8.1%	6.3%	17.7%
DP	DP Value	7.9%	4.0%	2.5%	2.2%	0.8%	8.8%	6.3%	18.5%	7.2%	4.0%	2.5%	2.2%	0.8%	10.8%	6.3%	17.7%	7.2%	4.0%	2.5%	2.2%	0.8%	8.1%	6.3%	17.7%
HNY	HNY EPO	8.6%	4.0%	2.5%	2.2%	0.8%	9.5%	6.3%	19.3%	7.2%	4.0%	2.5%	2.2%	0.8%	10.8%	6.3%	17.7%	7.2%	4.0%	2.5%	2.2%	0.8%	8.1%	6.3%	17.7%
Professional																									
SG	GHI-PPO	2.5%	2.0%	0.5%	9.0%	0.0%	2.5%	11.2%	14.5%	2.5%	2.0%	0.5%	6.0%	0.0%	3.0%	8.1%	11.4%	2.5%	2.0%	0.5%	6.0%	0.0%	2.5%	8.1%	11.4%
SG	GHI-EPO	2.5%	2.0%	0.5%	4.5%	0.0%	2.5%	6.6%	9.8%	2.5%	2.0%	0.5%	3.0%	0.0%	3.0%	5.1%	8.2%	2.5%	2.0%	0.5%	3.0%	0.0%	2.5%	5.1%	8.2%
SG	EPO Share	2.5%	2.0%	1.0%	3.0%	0.0%	2.5%	5.1%	8.8%	2.5%	2.0%	1.0%	2.0%	0.0%	3.5%	4.0%	7.7%	2.5%	2.0%	1.0%	2.0%	0.0%	2.5%	4.0%	7.7%
SG	CDHP EPO	2.5%	2.0%	5.0%	4.7%	0.0%	2.5%	6.8%	14.9%	2.5%	2.0%	5.0%	3.1%	0.0%	7.6%	5.2%	13.2%	2.5%	2.0%	5.0%	3.1%	0.0%	2.5%	5.2%	13.2%
SG	CDHP PPO	2.5%	2.0%	2.5%	9.0%	0.0%	2.5%	11.2%	16.8%	2.5%	2.0%	2.5%	6.0%	0.0%	5.1%	8.1%	13.6%	2.5%	2.0%	2.5%	6.0%	0.0%	2.5%	8.1%	13.6%
SG	SBAP	2.5%	2.0%	0.5%	9.0%	0.0%	2.5%	11.2%	14.5%	2.5%	2.0%	0.5%	6.0%	0.0%	3.0%	8.1%	11.4%	2.5%	2.0%	0.5%	6.0%	0.0%	2.5%	8.1%	11.4%
SG	HCTC	2.5%	2.0%	1.0%	4.5%	0.0%	2.5%	6.6%	10.3%	2.5%	2.0%	1.0%	3.0%	0.0%	3.5%	5.1%	8.8%	2.5%	2.0%	1.0%	3.0%	0.0%	2.5%	5.1%	8.8%
DP	DP Core	2.5%	2.0%	2.5%	2.2%	0.0%	2.5%	4.2%	9.5%	2.5%	2.0%	2.5%	2.2%	0.0%	5.1%	4.2%	9.5%	2.5%	2.0%	2.5%	2.2%	0.0%	2.5%	4.2%	9.5%
DP	DP Value	2.5%	2.0%	2.5%	2.2%	0.0%	2.5%	4.2%	9.5%	2.5%	2.0%	2.5%	2.2%	0.0%	5.1%	4.2%	9.5%	2.5%	2.0%	2.5%	2.2%	0.0%	2.5%	4.2%	9.5%
HNY	HNY EPO	2.5%	2.0%	1.0%	2.2%	0.0%	2.5%	4.2%	7.9%	2.5%	2.0%	1.0%	2.2%	0.0%	3.5%	4.2%	7.9%	2.5%	2.0%	1.0%	2.2%	0.0%	2.5%	4.2%	7.9%
Rx																									
SG	GHI-PPO	0.2%	2.0%	0.5%	9.0%	0.0%	0.2%	11.2%	12.0%	4.2%	2.0%	0.5%	6.0%	0.0%	4.7%	8.1%	13.2%	4.2%	2.0%	0.5%	6.0%	0.0%	4.2%	8.1%	13.2%
SG	GHI-EPO	0.2%	2.0%	0.5%	4.5%	0.0%	0.2%	6.6%	7.4%	4.1%	2.0%	0.5%	3.0%	0.0%	4.6%	5.1%	9.9%	4.1%	2.0%	0.5%	3.0%	0.0%	4.1%	5.1%	9.9%
SG	EPO Share	0.2%	2.0%	1.0%	3.0%	0.0%	0.2%	5.1%	6.4%	4.1%	2.0%	1.0%	2.0%	0.0%	5.2%	4.0%	9.4%	4.1%	2.0%	1.0%	2.0%	0.0%	4.1%	4.0%	9.4%
SG	CDHP EPO	0.2%	2.0%	5.0%	4.7%	0.0%	0.2%	6.8%	12.4%	4.2%	2.0%	5.0%	3.1%	0.0%	9.4%	5.2%	15.1%	4.2%	2.0%	5.0%	3.1%	0.0%	4.2%	5.2%	15.1%
SG	CDHP PPO	0.2%	2.0%	2.5%	9.0%	0.0%	0.2%	11.2%	14.2%	4.2%	2.0%	2.5%	6.0%	0.0%	6.8%	8.1%	15.5%	4.2%	2.0%	2.5%	6.0%	0.0%	4.2%	8.1%	15.5%
SG	SBAP	0.2%	2.0%	0.5%	9.0%	0.0%	0.2%	11.2%	12.0%	4.2%	2.0%	0.5%	6.0%	0.0%	4.7%	8.1%	13.2%	4.2%	2.0%	0.5%	6.0%	0.0%	4.2%	8.1%	13.2%
SG	HCTC	0.2%	2.0%	1.0%	4.5%	0.0%	0.2%	6.6%	7.9%	4.1%	2.0%	1.0%	3.0%	0.0%	5.2%	5.1%	10.5%	4.1%	2.0%	1.0%	3.0%	0.0%	4.1%	5.1%	10.5%
DP	DP Core	0.2%	2.0%	2.5%	2.2%	0.0%	0.2%	4.2%	7.1%	4.2%	2.0%	2.5%	2.2%	0.0%	6.8%	4.2%	11.3%	4.2%	2.0%	2.5%	2.2%	0.0%	4.2%	4.2%	11.3%
DP	DP Value	0.2%	2.0%	2.5%	2.2%	0.0%	0.2%	4.2%	7.1%	4.2%	2.0%	2.5%	2.2%	0.0%	6.8%	4.2%	11.3%	4.2%	2.0%	2.5%	2.2%	0.0%	4.2%	4.2%	11.3%
HNY	HNY EPO	0.2%	2.0%	1.0%	2.2%	0.0%	0.2%	4.2%	5.5%	4.1%	2.0%	1.0%	2.2%	0.0%	5.1%	4.2%	9.6%	4.1%	2.0%	1.0%	2.2%	0.0%	4.1%	4.2%	9.6%

Appendix G

Relative Non Rescaled Concurrent Risk Scores
New Medical/Rx Commercial DCG Model

Market	Jan 10 to Dec 10	Jan 11 to Dec 11	Risk Score Trends
EPO	137.57	143.75	4.5%
EPO Share	119.40	122.95	3.0%
EPO CDHP	125.87	133.07	5.7%
PPO	199.84	231.21	15.7%
PPO CDHP	130.31	149.96	15.1%
Direct Pay	171.25	175.00	2.2%

Appendix H-1
GHI Off Exchange Membership
Membership by Former Product

		Base Period Membership		
Product Name	**Group Size**	Members	% of Members	2012 PMPM
CDHP EPO	Small	18,557	16.5%	$284.33
CDHP PPO	Small	4,978	4.4%	$431.27
EPO Share	Small	23,619	21.0%	$277.27
GHI-EPO	Small	61,214	54.5%	$375.14
GHI-PPO	Small	3,451	3.1%	$708.39
HCTC	Small	31	0.0%	$275.25
SBAP	Small	554	0.5%	$585.97
Total		**112,403**	**100.0%**	**$353.31**

		2014 Expected Membership		
Product Name	**Group Size**	Members	% of Members	2012 PMPM
CDHP EPO	Small	10,392	23.3%	$284.33
CDHP PPO	Small	2,091	4.7%	$431.27
EPO Share	Small	9,920	22.2%	$277.27
GHI-EPO	Small	21,425	48.0%	$375.14
GHI-PPO	Small	725	1.6%	$708.39
HCTC	Small	9	0.0%	$275.25
SBAP	Small	116	0.3%	$585.97
Total		**44,677**	**100.0%**	**$340.85**

PMPM change -3.5%

Appendix J
Mandates and EHB Adjustments

Mandates	**PMPM**
Women's Health	$ 4.58
Autism	$ 3.78
Total Mandates	**$ 8.36**

Essential Health Benefits	**PMPM**
Rx Formulary	$ (1.00)
Mental Health/Substance Abuse	$ 3.41
Total EHB	**$ 2.41**

Total Mandates and EHB	**$ 10.77**

Appendix N-2
Risk Adjustment Summary

Product Name	Group Size	Members	% of Members	Risk Adj
CDHP EPO	Sole P	0	0.0%	
CDHP PPO	Sole P	0	0.0%	
Core	Individual	0	0.0%	
HNY EPO	Sole P	0	0.0%	
HNY EPO	Individual	0	0.0%	
HNY EPO CDHP	Sole P	0	0.0%	
HNY EPO CDHP	Individual	0	0.0%	
SBAP	Sole P	0	0.0%	
Value	Individual	0	0.0%	
CDHP EPO	Small	10,392	23.3%	$ 62.72
CDHP PPO	Small	2,091	4.7%	$ 62.72
EPO Share	Small	9,920	22.2%	$ 62.72
GHI-EPO	Small	21,425	48.0%	$ 62.72
GHI-PPO	Small	725	1.6%	$ 62.72
HCTC	Small	9	0.0%	$ 62.72
HNY EPO	Small	0	0.0%	$ 62.72
HNY EPO CDHP	Small	0	0.0%	$ 62.72
SBAP	Small	116	0.3%	$ 62.72
Total		**44,677**	**100.0%**	**$ 62.72**

Appendix P
GHI SG Off Exchange Pricing

		Row
Paid Total	**$ 449.28**	1
Ancillary Caps	$ -	2
HCRA Surcharge (Included in Allowed)	0.00%	3
No Rx Coverage Adjustment	16.4%	4
Formulary Adjustment	($3.15)	5
EHB Adjustment	$10.77	6
Rx Rebates	**-9.8%**	7
Include MG/GR members	**0.0%**	8
SelectCare Network Savings	**0.0%**	9
AgeSex Distribution	**0.0%**	10
Uninsured Pent-Up Demand	**0.0%**	11
Uninsured Morbidity	**0.0%**	12
Current Pricing AV	0.7778	13
Expected Pricing AV	0.6185	14
Expected/Current Pricing AV	**0.7952**	15
Current Induced Demand	1.0738	16
Expected Induced Demand	1.0000	17
CSR Induced Demand Factor	1.0000	18
Composite Expected and CSR Induced Demand	1.0000	19
Expected/Current Induced Demand	**0.9313**	20
Required Revenue due to Catastrophic	**1.0000**	21
Index Rate	**$ 341.82**	22
Risk Adjustments	$ 62.72	23
Reinsurance	$ -	24
Adjusted Index Rate	**$ 404.55**	25

	Bronze
Deductible	$6,300
Coinsurance Max	$0
IP Copay	0%
OP Facility/Surgery	0%
PCP	0%
SPC	0%
PT/OT/ST	0%
ER	0%
Ambulance	0%
Urgent Care	0%
DME	0%
Rx	$0/$0/$0

Percent Membership by Metal		100.0%	26
Members by Metal		**44,677**	27
Bottoms Up Model PMPM	**$**	**346.74**	28
Pricing Actuarial Value (Paid/Allowed ratio)		**0.6185**	29
Expected Pricing AV		**0.6185**	30
Composite Pricing AV		**1.0000**	31
Induced Demand Factor		**1.0000**	32
Expected Induced Demand		**1.0000**	33
Composite Induced Demand		**1.0000**	34
Age/Sex Factor for Castastrophic		**1.0000**	35
Top Down Adjusted PMPM - Adjusted for Plan Specific	**$**	**341.82**	36
Risk Adjustment			37
Risk Adjustment PMPM		**62.72**	38
Top Down Adjusted PMPM - Total	**$**	**404.55**	39
HCRA CLA	$	8.16	40
Top Down Adjusted PMPM w HCRA	**$**	**412.70**	41
PCORI	$	0.18	42
Exchange Fee	$	-	43
Reinsurance Fee	$	5.25	44
Insurance Fee		1.50%	45
Risk Adjustment Fee	$	0.08	46
Total ACA Fees - Based off Total PMPM	**$**	**12.53**	47
MLR Reclass		0.70%	48
332 Assessments		0.95%	49
Commissions		0.00%	50
All Other Admin		6.50%	51
Total Admin		**8.15%**	52
Margin		1.00%	53
Final PMPM - Total	**$**	**468.06**	54

Regional Factors		
Downstate Excl Long Island	0.955	55
LongIsland	1.029	56
AlbanyArea	0.893	57
BuffaloArea	0.826	58
Mid_HudsonArea	0.979	59
RochesterArea	0.807	60
SyracuseArea	0.865	61
Utica_WatertownArea	0.903	62
Final PMPM - Downstate Excl Long Island	**$ 447.14**	63
Final PMPM - Long Island	**$ 481.63**	64
Final PMPM - AlbanyArea	**$ 418.07**	65
Final PMPM - BuffaloArea	**$ 386.80**	66
Final PMPM - Mid_HudsonArea	**$ 458.09**	67
Final PMPM - RochesterArea	**$ 377.86**	68
Final PMPM - SyracuseArea	**$ 404.68**	69
Final PMPM - Utica_WatertownArea	**$ 422.56**	70
PEPM Adjustment	1.2060	71
Downstate Excl Long Island		
Individual	**$ 539.25**	72
Individual + Spouse	**$ 1,078.50**	73
Individual + Child(ren)	**$ 916.73**	74
Family	**$ 1,536.86**	75
Long Island		
Individual	**$ 580.85**	76
Individual + Spouse	**$ 1,161.70**	77
Individual + Child(ren)	**$ 987.45**	78
Family	**$ 1,655.42**	79
AlbanyArea		
Individual	**$ 504.19**	80
Individual + Spouse	**$ 1,008.38**	81
Individual + Child(ren)	**$ 857.12**	82
Family	**$ 1,436.94**	83
BuffaloArea		
Individual	**$ 466.49**	84
Individual + Spouse	**$ 932.98**	85
Individual + Child(ren)	**$ 793.03**	86
Family	**$ 1,329.50**	87
Mid_HudsonArea		
Individual	**$ 552.46**	88
Individual + Spouse	**$ 1,104.92**	89
Individual + Child(ren)	**$ 939.18**	90
Family	**$ 1,574.51**	91
RochesterArea		
Individual	**$ 455.70**	92
Individual + Spouse	**$ 911.40**	93
Individual + Child(ren)	**$ 774.69**	94
Family	**$ 1,298.75**	95
SyracuseArea		
Individual	**$ 488.05**	96
Individual + Spouse	**$ 976.10**	97
Individual + Child(ren)	**$ 829.69**	98
Family	**$ 1,390.94**	99
Utica_WatertownArea		
Individual	**$ 509.61**	100
Individual + Spouse	**$ 1,019.22**	101
Individual + Child(ren)	**$ 866.34**	102
Family	**$ 1,452.39**	103

Appendix Q
Regional Summary

Exchange State - Allowed/Risk Score

	Avg Mem	Member Distribution	Risk Score	Ipt Allowed	Opt Allowed	Prf Allowed	Rx Allowed	Ipt Allowed/ Risk Score	Opt Allowed/ Risk Score	Prf Allowed/Risk Score	Rx Allowed/ Risk Score
Total	95,681	100%	1.26	$150.78	$116.14	$185.34	$99.78	$119.34	$91.93	$146.70	$78.98
Downstate Excl Long Island	52,635	55%	1.27	$141.75	$109.94	$179.98	$96.66	$112.00	$86.86	$142.21	$76.37
LongIsland	38,261	40%	1.23	$144.54	$115.58	$190.81	$102.43	$117.45	$93.92	$155.05	$83.23
AlbanyArea	524	1%	1.72	$123.84	$125.13	$197.70	$124.04	$71.85	$72.60	$114.70	$71.96
BuffaloArea	330	0%	1.80	$114.15	$136.62	$149.16	$139.13	$63.33	$75.79	$82.75	$77.19
Mid_HudsonArea	2,197	2%	1.35	$133.99	$162.74	$182.72	$96.40	$99.50	$120.85	$135.69	$71.59
RochesterArea	132	0%	2.18	$213.31	$128.74	$78.22	$143.84	$97.91	$59.09	$35.91	$66.02
SyracuseArea	584	1%	1.60	$97.61	$201.05	$141.36	$124.68	$60.85	$125.33	$88.13	$77.73
Utica_WatertownArea	456	0%	1.81	$148.26	$337.70	$136.25	$130.83	$81.80	$186.32	$75.18	$72.18

Regional Factors - Cost/Service Only	**Ipt**	**Opt**	**Prof**	**Rx**	**Weighted**
Weights	27.3%	21.0%	33.6%	18.1%	
Downstate Excl Long Island	0.938	0.945	0.969	0.967	0.955
LongIsland	0.984	1.022	1.057	1.054	1.029
AlbanyArea	0.602	0.790	0.782	0.911	0.758
BuffaloArea	0.531	0.824	0.564	0.977	0.684
Mid_HudsonArea	0.834	1.315	0.925	0.906	0.979
RochesterArea	0.820	0.643	0.245	0.836	0.593
SyracuseArea	0.510	1.363	0.601	0.984	0.806
Utica_WatertownArea	0.685	2.027	0.512	0.914	0.951

	Lastest Approved Factors						
	AL	BU	DN	MH	RO	SY	UT
EPO/PPO/EPO Share/PPO Share	0.920	0.850	1.000	0.990	0.830	0.890	0.930
EPO HDHP/PPO HDHP	0.950	0.880	1.000	1.000	0.860	0.920	0.960
Average	0.935	0.865	1.000	0.995	0.845	0.905	0.945

Regional Factors	**Experience**	**Latest Approved Factors**	**Final Area Factors**
Downstate Excl Long Island	0.955	1.000	0.955
LongIsland	1.029		1.029
AlbanyArea		0.935	0.893
BuffaloArea		0.865	0.826
Mid_HudsonArea	0.979		0.979
RochesterArea		0.845	0.807
SyracuseArea		0.905	0.865
Utica_WatertownArea		0.945	0.903

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Appendix R

PMPM To Individual Conversion Factor

Adult/Child	10/11-9/12 Member Months	10/11-9/12 Allowed Trended To 2014	2014 Allowed PMPM
Adult	1,246,257	$653,197,601	$524.13
Child	426,260	$99,650,854	$233.78
Total	**1,672,517**	**$752,848,455**	**$450.13**

Rate Tier	3/13 Lives Per Contract	PCPM Cost	3/13 Contract Distribution	Composite PCPM	NYS Tier Ratio	NYS PCPM Cost	NYS Composite PCPM	Adjusted NYS PCPM Cost	Adjusted NYS Composite PCPM	PMPM To Indiviudal Conversion Factor
Ind	1.00	$524.13	62.0%	$325.03		$524.13	$325.03	$542.86	$336.64	
EC	2.95	$978.91	6.7%	$66.03	1.70	$891.02	$60.10	$922.85	$62.24	
ES	2.00	$1,048.26	6.5%	$67.62	2.00	$1,048.26	$67.62	$1,085.71	$70.04	
ESC	4.31	$1,588.36	24.8%	$393.77	2.85	$1,493.76	$370.32	$1,547.14	$383.56	
Total	**2.02**		**100.0%**	**$852.45**			**$823.07**		**$852.48**	**1.206**

Appendix R-1 Quarterly Step-Up
GHI SG

Trend

2014	2015
12.8%	12.8%

2014Q1	2014Q2	2014Q3	2014Q4
$ 468.06	$ 482.37	$ 497.11	$ 512.31

PCORI 5%

10/13-9/14	10/14-9/15
$ 0.18	$ 0.19

2014Q1	2014Q2	2014Q3	2014Q4
$ -	$ 0.00	$ 0.01	$ 0.01

Reinsurance

2014	2015
$ 5.25	$ 3.41

2014Q1	2014Q2	2014Q3	2014Q4
$ -	$ (0.46)	$ (0.92)	$ (1.38)

Ins. Asmt.

2014	2015
1.5%	2.0%

2014Q1	2014Q2	2014Q3	2014Q4
$ -	$ 0.60	$ 1.24	$ 1.92

	2014Q1	2014Q2	2014Q3	2014Q4
Total	$ 468.06	$ 482.51	$ 497.44	$ 512.85
Quarterly Step-Up		**1.031**	**1.031**	**1.031**

Appendix S
Untrended to Trended Paids

	Untrended	Trended
Total Paid	**$340.85**	**$454.58**
CDHP Rx Adjustment	-$3.82	-$5.31
Total Paid after CDHP Rx Adjustment	**$337.03**	**$449.28**
Ancillary Caps	$0.00	$0.00
HCRA Surcharge (Included in Allowed)	$0.00	$0.00
No Rx Coverage Adjustment	$9.08	$11.64
Formulary Adjustment	-$2.46	-$3.15
Rx Rebates	-$5.43	-$6.96
Total	**$338.23**	**$450.81**

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Appendix T

Small Group Age 30 Factor Calculation

Rate Tier	3/13 Contract Distribution	Proposed 01/01/2014 Rate	Age 30 Factor Family Tiers	Age 30 Cost	Age 30 Factor All Tiers
Ind	62.0%	$539.25	1.000	$539.25	
EC	6.7%	$916.73	1.040	$953.40	
ES	6.5%	$1,078.50	1.000	$1,078.50	
ESC	24.8%	$1,536.86	1.040	$1,598.33	
Total	**100.0%**	**$846.82**		**$864.53**	**1.021**