

State: New York **Filing Company:** Aetna Health Inc. (NY)
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only
 - HMO
Product Name: NY SG AHI 1Q14-4Q14
Project Name/Number: NY SG AHI 1Q14-4Q14/

Filing at a Glance

Company: Aetna Health Inc. (NY)
 Product Name: NY SG AHI 1Q14-4Q14
 State: New York
 TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)
 Sub-TOI: HOrg02G.004F Small Group Only - HMO
 Filing Type: Off Exchange NG Forms & Rates
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 [Redacted]

Disposition Date:
 Disposition Status:
 Implementation Date:
 State Filing Description:

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General Information

Project Name: NY SG AHI 1Q14-4Q14 Status of Filing in Domicile:
 Project Number: Date Approved in Domicile:
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 Group Market Type: Overall Rate Impact:
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 Created By: [Redacted] Submitted By: [Redacted]
 Corresponding Filing Tracking Number:

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Filing Description:
 This filing is for NY SG AHI rates 1Q14-4Q14

Company and Contact

Filing Contact Information

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 980 Jolly Road [Redacted] [Phone]
 M.S. U12S
 Blue Bell, PA 19422

Filing Company Information

Aetna Health Inc. (NY)	CoCode: 95234	State of Domicile: New York
60 Charles Lindbergh Boulevard	Group Code: 1	Company Type:
Suite 105	Group Name:	State ID Number:
Uniondale, NY 11553-3645	FEIN Number: 22-2663623	
(999) 999-9999 ext. [Phone]		

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State Specific

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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.): Yes. AHIC - AETN-129024449, ALIC - AETN-128993202
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Commercial
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.): Blanket
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

Section XIV.
Gold Healthy New York SCHEDULE OF BENEFITS
Gold

<p>COST-SHARING</p> <p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family 	<p>Participating Member Responsibility for Cost-Sharing</p> <p>\$600 \$1,200</p> <p>\$4,000 \$8,000</p>	
<p>OFFICE VISITS</p>	<p>Participating Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$25 Copayment after Deductible</p>	<p>See Benefit For Description</p>
<p>Specialist Office Visits (or Home Visits)</p> <p>Referral Required</p>	<p>\$40 Copayment after Deductible</p>	<p>See Benefit For Description</p>
<p>PREVENTIVE CARE</p>	<p>Participating Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* • Adult Annual Physical Examinations* • Adult Immunizations* 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>See Benefit For Description</p>

<ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* • Mammography Screenings* • Sterilization Procedures for Women* • Vasectomy • Bone Density Testing* • Screening for Prostate Cancer • All other preventive services required by USPSTF and HRSA. • *When preventive services are not provided in accordance with the 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Use Cost Sharing for Appropriate Service</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Use Cost Sharing for Appropriate Service (Primary Care Office Visit;</p>	
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comprehensive guidelines supported by USPSTF and HRSA. Referral Required	Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
EMERGENCY CARE	Participating Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment after Deductible	See Benefit For Description
Non-Emergency Ambulance Services Preauthorization Required	\$150 Copayment after Deductible	See Benefit For Description
Emergency Department Copayment waived if Hospital admission.	\$150 Copayment after Deductible	See Benefit For Description
Urgent Care Center	\$60 Copayment after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services Preauthorization Required	\$40 Copayment after Deductible \$40 Copayment after Deductible	See Benefit For Description
Allergy Testing & Treatment Referral Required	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee Preauthorization Required	\$100 Copayment after Deductible	See Benefit For Description

Anesthesia Services (all settings) Referral Required	Covered in full	See Benefit For Description
Autologous Blood Banking Preauthorization or Referral Required	\$0 Copayment after Deductible	See Benefits For Description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services Referral Required	\$40 Copayment after Deductible \$30 Copayment after Deductible \$1,000 Copayment after Deductible	See Benefits For Description
Chemotherapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services Referral Required	\$25 Copayment after Deductible \$40 Copayment after Deductible \$25 Copayment after Deductible	See Benefit For Description
Chiropractic Services Referral Required	\$40 Copayment after Deductible	See Benefit For Description
Diagnostic Testing		See Benefit For Description

<ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services <p>Referral Required</p>	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	
<p>Dialysis</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services <p>Preauthorization or Referral Required</p>	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>See Benefit For Description</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p>Referral Required</p>	<p>\$30 Copayment after Deductible</p>	<p>60 visits per condition, per lifetime combined therapies</p>
<p>Home Health Care</p> <p>Referral Required</p>	<p>\$25 Copayment after Deductible</p>	<p>40 Visits per Plan Year</p>
<p>Infertility Services</p>	<p>Use Cost Sharing for</p>	<p>See Benefit For Description</p>

<p>Preauthorization or Referral Required</p>	<p>Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)</p>	
<p>Infusion Therapy</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy <p>Referral Required</p>	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>See Benefit For Description</p> <p>Home Infusion counts towards Home Health Care Visit Limits</p>
<p>Inpatient Medical Visits</p> <p>Referral Required</p>	<p>\$0 Copayment after Deductible</p>	<p>See Benefit For Description</p>
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services <p>Referral Required</p>	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>See Benefit For Description</p>

<p>Maternity & Newborn Care</p> <ul style="list-style-type: none"> • Prenatal Care <ul style="list-style-type: none"> • Inpatient Hospital Services and Birthing Center <ul style="list-style-type: none"> • Physician and Nurse Midwife Services for Delivery <ul style="list-style-type: none"> • Breast Pump <p>Preauthorization Required</p>	<p>Covered In Full</p> <p>\$1,000 Copayment per admission after Deductible</p> <p>\$100 Copayment per admission after Deductible</p> <p>Covered in Full</p>	<p>See Benefit For Description</p> <p>1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p> <p>Preauthorization Required</p>	<p>\$100 Copayment after Deductible</p>	<p>See Benefit For Description</p>
<p>Preadmission Testing</p> <p>Referral Required</p>	<p>\$0 Copayment after Deductible</p>	<p>See Benefit For Description</p>
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services <p>Referral Required</p>	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>See Benefit For Description</p>
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a Freestanding 	<p>\$40 Copayment after Deductible</p>	<p>See Benefit For Description</p>

<p>Radiology Facility or Specialist Office</p> <ul style="list-style-type: none"> • Performed as Outpatient Hospital Services <p>Referral Required</p>	<p>\$25 Copayment after Deductible</p>	
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p>Referral Required</p>	<p>\$30 Copayment after Deductible</p>	<p>60 visits per condition, per lifetime combined therapies.</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery & Other</p> <p>Referral Required</p>	<p>\$40 Copayment after Deductible</p>	<p>See Benefit For Description</p>
<p>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery <p>Preauthorization or Referral Required</p>	<p>\$1,000 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>See Benefit For Description</p> <p>All Transplants Must be Performed at Designated Facilities</p>

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder Referral Required	\$25 Copayment after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder Referral Required	\$25 Copayment after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education Referral Required	\$25 Copayment after Deductible (See the Prescription Drug Cost-Sharing) \$25 Copayment after Deductible (See the Prescription Drug Cost-Sharing)	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment & Braces Referral Required	20% Coinsurance after Deductible	See Benefit For Description
External Hearing Aids Referral Required	20% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants Referral Required	20% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care <ul style="list-style-type: none"> • Inpatient 	\$1,000 Copayment per admission after Deductible	210 Days per Plan Year 5 Visits for Family Bereavement Counseling

<ul style="list-style-type: none"> • Outpatient <p>Preauthorization or Referral Required</p>	\$25 Copayment after Deductible	
<p>Medical Supplies</p> <p>Referral Required</p>	20% Coinsurance after Deductible	See Benefit For Description
<p>Prosthetic Devices</p> <ul style="list-style-type: none"> • External <ul style="list-style-type: none"> • Internal <p>Referral Required</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>One prosthetic device, per limb, per lifetime</p> <p>Unlimited See Benefit For Description</p>
INPATIENT SERVICES & FACILITIES	Participating Member Responsibility for Cost-Sharing	Limits
<p>Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)</p> <p>Preauthorization Required</p>	\$1,000 Copayment per admission after Deductible	See Benefit For Description
<p>Observation Stay</p> <p>Referral Required</p>	\$150 Copayment after Deductible	See Benefit For Description
<p>Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)</p> <p>Preauthorization Required</p>	\$1,000 Copayment per admission after Deductible	200 Days Per Plan Year
<p>Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)</p> <p>Preauthorization Required</p>	\$1,000 Copayment per admission after Deductible	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE	Participating Member Responsibility for Cost-	Limits

DISORDER SERVICES	Sharing	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) Preauthorization Required	\$1,000 Copayment per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) Referral Required	\$25 Copayment after Deductible	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) Preauthorization Required	\$1,000 Copayment per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services Referral Required	\$25 Copayment after Deductible	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy		
30 Day Supply Tier 1	\$ 10 Copayment after Deductible	See Benefit For Description
Tier 2	\$ 35 Copayment after Deductible	
Tier 3	\$ 70 Copayment after Deductible	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1	\$25 Copayment after Deductible	See Benefit For Description
Tier 2	\$87.50 Copayment after Deductible	
Tier 3	\$175 Copayment	

	after Deductible	
WELLNESS BENEFITS	Participating Member Responsibility for Cost-Sharing	
Gym Reimbursement	Not Applicable	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse
PEDIATRIC DENTAL & VISION CARE	Participating Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care <ul style="list-style-type: none"> • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia 	0% Coinsurance, not subject to Deductible 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care <ul style="list-style-type: none"> • Exams • Lenses & Frames • Contact Lenses Preauthorization or Referral Required	\$25 Copayment after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
NYC Community PlanSM \$20 HMO SCHEDULE OF BENEFITS
Platinum

<p>COST-SHARING</p> <p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family 	<p>Participating Member Responsibility for Cost-Sharing</p> <p>None None</p> <p>\$1,000 \$2,000</p>	
<p>OFFICE VISITS</p>	<p>Participating Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$20 Copayment</p>	<p>See Benefit For Description</p>
<p>Specialist Office Visits (or Home Visits)</p>	<p>\$35 Copayment</p>	<p>See Benefit For Description</p>
<p>PREVENTIVE CARE</p>	<p>Participating Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* • Adult Annual Physical Examinations* • Adult Immunizations* 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>See Benefit For Description</p>

<ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* 	Covered in full	
<ul style="list-style-type: none"> • Mammography Screenings* 	Covered in full	
<ul style="list-style-type: none"> • Sterilization Procedures for Women* 	Covered in full	
<ul style="list-style-type: none"> • Vasectomy 	Use Cost Sharing for Appropriate Service	
<ul style="list-style-type: none"> • Bone Density Testing* 	Covered in full	
<ul style="list-style-type: none"> • Screening for Prostate Cancer 	Covered in full	
<ul style="list-style-type: none"> • All other preventive services required by USPSTF and HRSA. 	Covered in full	
<ul style="list-style-type: none"> • *When preventive services are not provided in accordance with the 	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit;	

comprehensive guidelines supported by USPSTF and HRSA.	Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
EMERGENCY CARE	Participating Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$100 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	\$100 Copayment	See Benefit For Description
Preauthorization Required		
Emergency Department	\$100 Copayment	See Benefit For Description
Urgent Care Center	\$35 Copayment	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services 	\$35 Copayment \$35 Copayment	See Benefit For Description
Preauthorization Required		
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee	\$150 Copayment	See Benefit For Description
Preauthorization Required		
Anesthesia Services (all settings)	\$0 Copayment	See Benefit For Description

Autologous Blood Banking Preauthorization Required	\$0 Copayment	See Benefits For Description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services 	\$35 Copayment \$35 Copayment \$500 Copayment	See Benefits For Description
Chemotherapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	\$20 Copayment \$20 Copayment \$20 Copayment	See Benefit For Description
Chiropractic Services	\$35 Copayment	See Benefit For Description
Diagnostic Testing <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	\$20 Copayment \$35 Copayment	See Benefit For Description

<ul style="list-style-type: none"> • Performed as Outpatient Hospital Services 	\$35 Copayment	
Dialysis <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services Preauthorization Required	\$20 Copayment \$20 Copayment \$20 Copayment	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$35 Copayment	60 visits per Plan Year combined therapies
Home Health Care	\$20 Copayment	40 Visits per Plan Year
Infertility Services Preauthorization Required	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in 	\$20 Copayment \$20 Copayment	See Benefit For Description

<p>Specialist Office</p> <ul style="list-style-type: none"> • Performed as Outpatient Hospital Services • Home Infusion Therapy 	<p>\$20 Copayment</p> <p>\$20 Copayment</p>	
Inpatient Medical Visits	\$0 Copayment	See Benefit For Description
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services 	<p>\$0 Copayment</p> <p>\$0 Copayment</p> <p>\$0 Copayment</p>	<p>See Benefit For Description</p> <p>See Benefit For Description</p>
<p>Maternity & Newborn Care</p> <ul style="list-style-type: none"> • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for 	<p>Covered In Full</p> <p>\$500 Copayment</p> <p>\$35 Copayment</p>	<p>See Benefit For Description</p> <p>1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p>

<p>Delivery</p> <ul style="list-style-type: none"> • Breast Pump <p>Preauthorization Required</p>	Covered in Full	Covered for duration of breast feeding
<p>Outpatient Hospital Surgery Facility Charge</p> <p>Preauthorization Required</p>	\$150 Copayment	See Benefit For Description
Preadmission Testing	\$0 Copayment	See Benefit For Description
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services 	<p>\$20 Copayment</p> <p>\$35 Copayment</p> <p>\$35 Copayment</p>	See Benefit For Description
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services 	<p>\$35 Copayment</p> <p>\$35 Copayment</p>	See Benefit For Description
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	\$35 Copayment	60 visits per Plan Year combined therapies.

Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$35 Copayment	See Benefit For Description
<p>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery <p>Preauthorization Required</p>	<p>\$500 Copayment</p> <p>\$150 Copayment</p> <p>\$150 Copayment</p> <p>\$0 Copayment</p>	<p>See Benefit For Description</p> <p>All Transplants Must be Performed at Designated Facilities</p>
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	\$35 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	\$35 Copayment	See Benefit For Description
<p>Diabetic Equipment, Supplies & Self-Management Education</p> <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-Day Supply) 	\$20 Copayment	<p>See Benefit For Description</p> <p>See Prescription Drug Benefit</p>

<ul style="list-style-type: none"> • Diabetic Education 	\$20 Copayment	
Durable Medical Equipment & Braces	50% Coinsurance	See Benefit For Description
External Hearing Aids	50% Coinsurance	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance	One Per Ear Per Time Covered
Hospice Care <ul style="list-style-type: none"> • Inpatient <ul style="list-style-type: none"> • Outpatient Preauthorization Required	\$500 Copayment \$35 Copayment	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance	See Benefit For Description
Prosthetic Devices <ul style="list-style-type: none"> • External <ul style="list-style-type: none"> • Internal 	50% Coinsurance 50% Coinsurance	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	Participating Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) Preauthorization Required	\$500 Copayment per admission	See Benefit For Description
Observation Stay	\$100 Copayment	See Benefit For Description

Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) Preauthorization Required	\$500 Copayment per admission	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) Preauthorization Required	\$500 Copayment per admission	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Member Responsibility for Cost- Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) Preauthorization Required	\$500 Copayment per admission	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	\$35 Copayment	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) Preauthorization Required	\$500 Copayment per admission	See Benefit For Description
Outpatient Substance Use Services	\$35 Copayment	Unlimited
PRESCRIPTION DRUGS	Participating Member Responsibility for Cost- Sharing	Limits
Retail Pharmacy		
30 Day Supply Tier 1	\$10 Copayment	See Benefit For Description
Tier 2	\$50 Copayment	
Tier 3	50% Coinsurance up to \$750	

Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1	\$20 Copayment	See Benefit For Description
Tier 2	\$100 Copayment	
Tier 3	50% Coinsurance up to \$1,500	
WELLNESS BENEFITS	Participating Member Responsibility for Cost-Sharing	
Gym Reimbursement	Not Applicable	Up to \$150 per 12 month period; up to an additional \$150 per 12 month period for Spouse
PEDIATRIC DENTAL & VISION CARE	Participating Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care		One Dental Exam & Cleaning Per 6-Month Period
<ul style="list-style-type: none"> • Preventive 	0% Coinsurance	
<ul style="list-style-type: none"> • Routine Dental Care 	30% Coinsurance	
<ul style="list-style-type: none"> • Major Dental (Endodontics & Prosthodontics) 	50% Coinsurance	
<ul style="list-style-type: none"> • Orthodontia 	50% Coinsurance	
Pediatric Vision Care		One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period
<ul style="list-style-type: none"> • Exa ms 	\$35 Copayment	
<ul style="list-style-type: none"> • Lenses & Frames 	0% Coinsurance	
<ul style="list-style-type: none"> • Contact Lenses 	0% Coinsurance	

Section XIV.
NYC Community PlanSM \$30 HMO SCHEDULE OF BENEFITS
Platinum

<p>COST-SHARING</p> <p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family 	<p>Participating Member Responsibility for Cost-Sharing</p> <p>None None</p> <p>\$1,000 \$2,000</p>	
<p>OFFICE VISITS</p>	<p>Participating Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$30 Copayment</p>	<p>See Benefit For Description</p>
<p>Specialist Office Visits (or Home Visits)</p>	<p>\$50 Copayment</p>	<p>See Benefit For Description</p>
<p>PREVENTIVE CARE</p>	<p>Participating Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* • Adult Annual Physical Examinations* • Adult Immunizations* 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>See Benefit For Description</p>

<ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* 	Covered in full	
<ul style="list-style-type: none"> • Mammography Screenings* 	Covered in full	
<ul style="list-style-type: none"> • Sterilization Procedures for Women* 	Covered in full	
<ul style="list-style-type: none"> • Vasectomy 	Use Cost Sharing for Appropriate Service	
<ul style="list-style-type: none"> • Bone Density Testing* 	Covered in full	
<ul style="list-style-type: none"> • Screening for Prostate Cancer 	Covered in full	
<ul style="list-style-type: none"> • All other preventive services required by USPSTF and HRSA. 	Covered in full	
<ul style="list-style-type: none"> • *When preventive services are not provided in accordance with the 	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit;	

comprehensive guidelines supported by USPSTF and HRSA.	Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
EMERGENCY CARE	Participating Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$100 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	\$100 Copayment	See Benefit For Description
Preauthorization Required		
Emergency Department	\$150 Copayment	See Benefit For Description
Urgent Care Center	\$35 Copayment	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services 	\$50 Copayment \$50 Copayment	See Benefit For Description
Preauthorization Required		
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee	\$150 Copayment	See Benefit For Description
Preauthorization Required		
Anesthesia Services (all settings)	\$0 Copayment	See Benefit For Description

Autologous Blood Banking Preauthorization Required	\$0 Copayment	See Benefits For Description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services 	\$50 Copayment \$50 Copayment \$1,000 Copayment	See Benefits For Description
Chemotherapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	\$30 Copayment \$30 Copayment \$30 Copayment	See Benefit For Description
Chiropractic Services	\$50 Copayment	See Benefit For Description
Diagnostic Testing <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	\$30 Copayment \$50 Copayment	See Benefit For Description

<ul style="list-style-type: none"> • Performed as Outpatient Hospital Services 	\$50 Copayment	
Dialysis <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services Preauthorization Required	\$30 Copayment \$30 Copayment \$30 Copayment	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$50 Copayment	60 visits per Plan Year combined therapies
Home Health Care	\$30 Copayment	40 Visits per Plan Year
Infertility Services Preauthorization Required	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in Specialist Office 	\$30 Copayment \$30 Copayment	See Benefit For Description

<ul style="list-style-type: none"> • Performed as Outpatient Hospital Services 	\$30 Copayment	
<ul style="list-style-type: none"> • Home Infusion Therapy 	\$30 Copayment	
Inpatient Medical Visits	\$0 Copayment	See Benefit For Description
Laboratory Procedures		See Benefit For Description
<ul style="list-style-type: none"> • Performed in a PCP Office 	\$0 Copayment	
<ul style="list-style-type: none"> • Performed in a Freestanding Laboratory Facility or Specialist Office 	\$0 Copayment	
<ul style="list-style-type: none"> • Performed as Outpatient Hospital Services 	\$0 Copayment	
Maternity & Newborn Care		See Benefit For Description
<ul style="list-style-type: none"> • Prenatal Care 	Covered In Full	1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
<ul style="list-style-type: none"> • Inpatient Hospital Services and Birthing Center 	\$1,000 Copayment	
<ul style="list-style-type: none"> • Physician and Nurse Midwife Services for 	\$50 Copayment	

<p>Delivery</p> <ul style="list-style-type: none"> • Breast Pump <p>Preauthorization Required</p>	Covered in Full	Covered for duration of breast feeding
<p>Outpatient Hospital Surgery Facility Charge</p> <p>Preauthorization Required</p>	\$150 Copayment	See Benefit For Description
Preadmission Testing	\$0 Copayment	See Benefit For Description
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services 	<p>\$30 Copayment</p> <p>\$50 Copayment</p> <p>\$50 Copayment</p>	See Benefit For Description
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services 	<p>\$50 Copayment</p> <p>\$50 Copayment</p>	See Benefit For Description
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	\$50 Copayment	60 visits per Plan Year combined therapies.

Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$50 Copayment	See Benefit For Description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery 	\$1,000 Copayment \$150 Copayment \$150 Copayment \$0 Copayment	See Benefit For Description All Transplants Must be Performed at Designated Facilities
Preauthorization Required		
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	\$50 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	\$50 Copayment	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-Day Supply) 	\$30 Copayment	See Benefit For Description See Prescription Drug Benefit

<ul style="list-style-type: none"> • Diabetic Education 	\$30 Copayment	
Durable Medical Equipment & Braces	50% Coinsurance	See Benefit For Description
External Hearing Aids	50% Coinsurance	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance	One Per Ear Per Time Covered
Hospice Care <ul style="list-style-type: none"> • Inpatient <ul style="list-style-type: none"> • Outpatient Preauthorization Required	\$1,000 Copayment \$50 Copayment	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance	See Benefit For Description
Prosthetic Devices <ul style="list-style-type: none"> • External <ul style="list-style-type: none"> • Internal 	50% Coinsurance 50% Coinsurance	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	Participating Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) Preauthorization Required	\$1,000 Copayment per admission	See Benefit For Description
Observation Stay	\$150 Copayment	See Benefit For Description

Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) Preauthorization Required	\$1,000 Copayment per admission	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) Preauthorization Required	\$1,000 Copayment per admission	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Member Responsibility for Cost- Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) Preauthorization Required	\$1,000 Copayment per admission	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	\$50 Copayment	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) Preauthorization Required	\$1,000 Copayment per admission	See Benefit For Description
Outpatient Substance Use Services	\$50 Copayment	Unlimited
PRESCRIPTION DRUGS	Participating Member Responsibility for Cost- Sharing	Limits
Retail Pharmacy		
30 Day Supply Tier 1	\$10 Copayment	See Benefit For Description
Tier 2	\$50 Copayment	
Tier 3	50% Coinsurance up to \$750	

Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1	\$20 Copayment	See Benefit For Description
Tier 2	\$100 Copayment	
Tier 3	50% Coinsurance up to \$1,500	
WELLNESS BENEFITS	Participating Member Responsibility for Cost-Sharing	
Gym Reimbursement	Not Applicable	Up to \$150 per 12 month period; up to an additional \$150 per 12 month period for Spouse
PEDIATRIC DENTAL & VISION CARE	Participating Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care		One Dental Exam & Cleaning Per 6-Month Period
<ul style="list-style-type: none"> • Preventive 	0% Coinsurance	
<ul style="list-style-type: none"> • Routine Dental Care 	30% Coinsurance	
<ul style="list-style-type: none"> • Major Dental (Endodontics & Prosthodontics) 	50% Coinsurance	
<ul style="list-style-type: none"> • Orthodontia 	50% Coinsurance	
Pediatric Vision Care		One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period
<ul style="list-style-type: none"> • Exa ms 	\$50 Copayment	
<ul style="list-style-type: none"> • Lenses & Frames 	0% Coinsurance	
<ul style="list-style-type: none"> • Contact Lenses 	0% Coinsurance	

SERFF Tracking #:

AETN-128992632

State Tracking #:

2013050115

Company Tracking #:

State:

New York

Filing Company:

Aetna Health Inc. (NY)

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name:

NY SG AHI 1Q14-4Q14

Project Name/Number:

NY SG AHI 1Q14-4Q14/

Rate Information

Rate data applies to filing.

Filing Method:

SERFF

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

1.600%

Effective Date of Last Rate Revision:

01/01/2013

Filing Method of Last Filing:

SERFF

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):
Aetna Health Inc. (NY)	New Product	0.000%	0.000%	\$3,410,256	3,294	\$45,134,352	%	%

State: New York Filing Company: Aetna Health Inc. (NY)
 TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO
 Product Name: NY SG AHI 1Q14-4Q14
 Project Name/Number: NY SG AHI 1Q14-4Q14/

Rate Review Detail

COMPANY:

Company Name: Aetna Health Inc. (NY)
 HHS Issuer Id: 50138
 Product Names: Aetna Health Mainenance Organization
 Trend Factors:

FORMS:

New Policy Forms: OffHIXHNYGR-96816, OffHIXHNYGR-96816-Contra Rider, OffHIXHNYGR-96816-SB, OffHIXHNYGR-96816-DepsAge 29, HMO/NY HEALTHY HCRSBC-1, HMO/NY HEALTHY- PREMIUMS, OffHIXSGNYCCPHMOGR-96821, OffHIXSGNYCCPHMOGR-96821-Contra Rider, OffHIXSGNYCCPHMOGR-96821-Deps Age 29, OffHIXSG(HMONYCCPSM\$20)GR-96821-SB, OffHIXSG(HMONYCCPSM\$30)GR-96821-SB

Affected Forms:
 Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
 Member Months: 113,328
 Benefit Change: None
 Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium: 45,134,351.83
 Total Incurred Claims: 36,327,621.50
 Annual \$: Min: 363.00 Max: 1,326.00 Avg: 277.72

REQUESTED RATE:

Projected Earned Premium: 48,544,607.94
 Projected Incurred Claims: 39,661,828.97
 Annual \$: Min: 407.00 Max: 1,734.00 Avg: 298.71

State: New York

Filing Company: Aetna Health Inc. (NY)

TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name: NY SG AHI 1Q14-4Q14

Project Name/Number: NY SG AHI 1Q14-4Q14/

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		NY SG Rate Manual AHI	OffHIXHNYGR-96816, OffHIXHNYGR-96816-Contra Rider, OffHIXHNYGR-96816- SB, OffHIXHNYGR-96816- DepsAge 29, HMO/NY HEALTHY HCRSBC-1, HMO/NY HEALTHY- PREMIUMS, OffHIXSGNYCCPHMOGR- 96821, OffHIXSGNYCCPHMOGR- 96821-Contra Rider, OffHIXSGNYCCPHMOGR- 96821-Deps Age 29, OffHIXSG(HMONYCCPSM\$20)GR-96821-SB, OffHIXSG(HMONYCCPSM\$30)GR-96821-SB	New		NY SG Rate Manual - AHI.pdf,

Aetna Health Inc.
New York Small Group
Premium Rate Manual

Table of Contents

<u>Description</u>	<u>Page</u>
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Premium Rate Manual	A-2 – A-6
Product Summary and Actuarial Values	B-1 – B-13
Plan Relativity Factors	C-1
Rate Tables	D-1 – D-33
List of Applicable Forms	E-1
Exhibit A: Loss Ratio	F-1
Exhibit B: Underwriting and Marketing Guidelines	G-1
Exhibit C: Commissions Schedule and Incentive Fees	H-1

Aetna Health Inc.
New York Small Group
Premium Rate Manual

General

The attached pages contain worksheets and instructions for calculating the community rates for the plans available from Aetna Health Inc. (The Health Maintenance Organization of New York, Inc.). This filing is made in accordance with Insurance Law Section 4308 (c) Rate Applications and includes rates for our new products that will be offered effective January 1, 2014.

Aetna Health Inc.

New York Small Group

Premium Rate Manual

The following Steps are used to calculate premium rates.

1. 2014 Base Rate

Platinum Index Premium Rate
\$473.28

2. Plan Pricing Values

Plan Relativity Factor Table – rate factor for each unique plan design.

Base Rate x Plan Relativity Factor = Rate for Unique Plan

The product identifier will identify the plan. For each product identifier, there will be a rate relativity factor.

The plan factors shown on page C-1 reflect the pricing differential for each product.

3. Standardized Rating Region

Below is the NY SG rating area factor table - Rate factor to reflect differences in cost by geographic area. Base Rate x Plan Relativity Factor x Area Factor = Rate for that Plan for that Rating Area. The rating regions listed below are based on the required ACA standardized rating regions.

Rating Region	Counties	Area Factor
Region 1	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	0.9044
Region 2	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	0.9044
Region 3	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster	1.0000
Region 4	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester	1.0000
Region 5	Livingston, Monroe, Ontario, Seneca, Wayne, Yates	0.9044
Region 6	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins	0.9044
Region 7	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	0.9044
Region 8	Nassau, Suffolk	1.0000

Aetna Health Inc.

New York Small Group

Premium Rate Manual

4. **Effective Date Factor table** - premium rate level adjustment factor to reflect differences in cost by effective date.

	HMO
	Effective Date Factor
01/01/2014	1.0000
02/01/2014	1.0000
03/01/2014	1.0000
04/01/2014	1.0223
05/01/2014	1.0223
06/01/2014	1.0223
07/01/2014	1.0451
08/01/2014	1.0451
09/01/2014	1.0451
10/01/2014	1.0686
11/01/2014	1.0686
12/01/2014	1.0686

5. **Standardized Census Tiers**

All Aetna New York Individual products will be priced to reflect the tiers and relativities specified by the DFS.

Tier	Relativities
Single	1.00
Single + Spouse	2.00
Single + Child(ren)	1.70
Single + Spouse + Child(ren)	2.85

6. **Dependent Age Adjustment Factor**

For subscribers who choose to have the Dependent Up to Age 30 rider, the additional adjustment to the rate is as follows:

Aetna Health Inc.

New York Small Group

Premium Rate Manual

Non-Student Age	Student Age	Single	Parent & Child(ren)	Couple	Family
26	26	1.000	1.000	1.000	1.000
30	30	1.000	1.032	1.000	1.032

The rate for an unmarried young adult who chooses coverage under the Young Adult Option would be equal to the rate that would be paid by the young adult's subscriber/parent if that subscriber were billed as a single member.

7. Subscriber Rate

The subscriber rate is equal to Step 1 x Step 2 x Step 3 x Step 4 or Step 5 x Step 6, rounded to the nearest dollar.

Other coverage adjustment factor - NYC Community Plan adjustment factor(applied to medical rates table)[Factor = .90], which is already build into the NYCCP plan factors in rate manual section C.

8. Example of Rate Calculations

Base Rate * Plan Factor * Rating Area Factor * Effective Date factor * Tier Factor* Dep Age Adj. Factor

Region 1 with NYC Community Plan Platinum 30 – January 2014

Single:

Round ($\$473.28 * 0.964278 * 0.9044 * 1.0 * 1.0 * 1.0, 0$) = \$413

Single + Spouse:

Round ($\$473.28 * 0.964278 * 0.9044 * 1.0 * 2.0 * 1.0, 0$) = \$825

Single + Child(ren):

Round ($\$473.28 * 0.964278 * 0.9044 * 1.0 * 1.7 * 1.0, 0$) = \$702

Single + Child(ren) with Dependent Up to Age 30 Rider:

Round ($\$473.28 * 0.964278 * 0.9044 * 1.0 * 1.7 * 1.032, 0$) = \$724

Single + Spouse + Child(ren)

Round ($\$473.28 * 0.964278 * 0.9044 * 1.0 * 2.85 * 1.0, 0$) = \$1176

Single + Spouse + Child(ren) with Dependent Up to Age 30 Rider:

Round ($\$473.28 * 0.964278 * 0.9044 * 1.0 * 2.85 * 1.032, 0$) = \$1214

Aetna Health Inc.

New York Small Group

Premium Rate Manual

Region 8 with NYC Community Plan Platinum 30 – April 2014

Single:

Round ($\$473.28 * 0.964278 * 1.0 * 1.0223 * 1.0 * 1.0, 0$) = \$467

Single + Spouse:

Round ($\$473.28 * 0.964278 * 1.0 * 1.0223 * 2.0 * 1.0, 0$) = \$933

Single + Child(ren):

Round ($\$473.28 * 0.964278 * 1.0 * 1.0223 * 1.7 * 1.0, 0$) = \$793

Single + Child(ren) with Dependent Up to Age 30 Rider:

Round ($\$473.28 * 0.964278 * 1.0 * 1.0223 * 1.7 * 1.032, 0$) = \$819

Single + Spouse + Child(ren)

Round ($\$473.28 * 0.964278 * 1.0 * 1.0223 * 2.85 * 1.0, 0$) = \$1330

Single + Spouse + Child(ren) with Dependent Up to Age 30 Rider:

Round ($\$473.28 * 0.964278 * 1.0 * 1.0223 * 2.85 * 1.032, 0$) = \$1372

Aetna Health, Inc.
New York Small Group HMO Filing
SERFF ID: AETN-128992632
Exhibit B

New York Small Group HMO Portfolio | Summary of Benefits

Contents

NY GOLD HEALTHY NY2
NY PLATINUM NYC COMMUNITY PLANSM \$204
NY PLATINUM NYC COMMUNITY PLANSM \$306
NY GOLD HEALTHY NY RE8
NY PLATINUM NYC COMMUNITY PLANSM \$20 RE 10
NY PLATINUM NYC COMMUNITY PLANSM \$30 RE 12

Summary of Benefits Covered

NY GOLD HEALTHY NY

New York Small Group

Gold Plan

Summary of Features In-Network

Deductible	
Individual	\$600
Family	\$1,200
Coinsurance (Member Responsibility)	20%
	<i>\$0 once out-of-pocket max. is satisfied</i>
Out-of-Pocket Maximum	
Individual	\$4,000
Family	\$8,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	\$25 per visit after deductible
Specialist Visit	\$40 per visit after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	\$1,000/Admit after deductible
Emergency Room Services	\$150 per visit after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$25 per visit after deductible
Imaging (CT/PET Scans, MRIs)	\$40 per visit after deductible
Rehabilitative Speech Therapy	\$30 per visit after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$30 per visit after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	\$40 per visit after deductible
X-rays and Diagnostic Imaging	\$40 per visit after deductible
Skilled Nursing Facility	\$1,000/Admit after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100 per visit after deductible
Outpatient Surgery Physician/Surgical Services	\$100 per visit after deductible

Pharmacy In-Network

Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	\$10 copay
Preferred Brand Drugs	\$35 copay
Non-Preferred Brand Drugs	\$70 copay
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

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

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$34.08	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	96%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages: Calculation Successful.
 Actuarial Value: 79.0%
 Metal Tier: Gold

This product, NY Gold Healthy NY, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79%.

Summary of Benefits Covered

NY PLATINUM NYC COMMUNITY PLANSM \$20

New York Small Group

Platinum Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	N/A	
Family	N/A	
Coinsurance (Member Responsibility)	N/A	
	<i>\$0 once out-of-pocket max. is satisfied</i>	
Out-of-Pocket Maximum		
Individual	\$1,000	
Family	\$2,000	
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	\$20 per visit	30% after deductible
Specialist Visit	\$35 per visit	30% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	\$500/Admit	30% after deductible
Emergency Room Services	\$100 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$35 per visit	30% after deductible
Imaging (CT/PET Scans, MRIs)	\$35 per visit	30% after deductible
Rehabilitative Speech Therapy	\$35 per visit	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$35 per visit	30% after deductible
Preventive Care/Screening/Immunization	0%	30% after deductible
Laboratory Outpatient and Professional Services	0%	30% after deductible
X-rays and Diagnostic Imaging	\$35 per visit	30% after deductible
Skilled Nursing Facility	\$500/Admit	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150 per visit	30% after deductible
Outpatient Surgery Physician/Surgical Services	0%	30% after deductible
Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	\$10 copay	
Preferred Brand Drugs	\$50 copay	
Non-Preferred Brand Drugs	50% up to \$750	
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?

Apply Inpatient Copay per Day?

Apply Skilled Nursing Facility Copay per Day?

Rate OOP Maximum for Medical and Drug Spending?

Indicate if Plan Meets CSR Standard?

Desired Metal Tier: Platin

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input checked="" type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	92%
		2nd Tier Utilization:	8%

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00	\$5,000.00	\$0.00	
Coinsurance (%; Insurer's Cost Share)	100.00%	50.00%	70.00%	50.00%	
OOP Maximum (\$)	\$1,000.00		\$5,250.00		
OOP Maximum if Separate (\$)	\$1,000.00	\$0.00			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00

Options for Additional Benefit Design Limits:

a Maximum on Specialty Rx Coinsurance Payments?
Specialty Rx Coinsurance Maximum: \$750

Maximum Number of Days for Charging an IP Copay?
Days (1-10):

Primary Care Cost-Sharing After a Set Number of Visits?
Visits (1-10):

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
Copays (1-10):

Output

Calculate

Status/Error Messages: Calculation Successful.

Actuarial Value: 89.3%

Metal Tier: Platinum

This product, NY Platinum NYC Community PlansM \$20 satisfies the HHS guidelines for a Platinum plan with an Actuarial Value of 89.3%.

Summary of Benefits Covered

NY PLATINUM NYC COMMUNITY PLANSM \$30

New York Small Group

Platinum Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	N/A	
Family	N/A	
Coinsurance <i>(Member Responsibility)</i>	N/A	
<i>\$0 once out-of-pocket max. is satisfied</i>		
Out-of-Pocket Maximum		
Individual	\$1,000	
Family	\$2,000	
<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>		
Primary Care Visit to Treat an Injury or Illness <i>(excludes Preventative and X-rays)</i>	\$30 per visit	30% after deductible
Specialist Visit	\$50 per visit	30% after deductible
All Inpatient Hospital Services <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	\$1,000/Admit	30% after deductible
Emergency Room Services	\$150 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$50 per visit	30% after deductible
Imaging (CT/PET Scans, MRIs)	\$50 per visit	30% after deductible
Rehabilitative Speech Therapy	\$50 per visit	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$50 per visit	30% after deductible
Preventive Care/Screening/Immunization	0%	30% after deductible
Laboratory Outpatient and Professional Services	0%	30% after deductible
X-rays and Diagnostic Imaging	\$50 per visit	30% after deductible
Skilled Nursing Facility	\$1,000/Admit	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150 per visit	30% after deductible
Outpatient Surgery Physician/Surgical Services	0%	30% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	\$10 copay	
Preferred Brand Drugs	\$50 copay	
Non-Preferred Brand Drugs	50% up to \$750	
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?

Apply Inpatient Copay per Day?

Apply Skilled Nursing Facility Copay per Day?

Rate OOP Maximum for Medical and Drug Spending?

Indicate if Plan Meets CSR Standard?

Desired Metal Tier: Platin

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input checked="" type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	92%
		2nd Tier Utilization:	8%

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00	\$5,000.00	\$0.00	
Coinsurance (%; Insurer's Cost Share)	100.00%	50.00%	70.00%	50.00%	
OOP Maximum (\$)	\$1,000.00		\$5,250.00		
OOP Maximum if Separate (\$)	\$1,000.00	\$0.00			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input type="checkbox"/>	<input type="checkbox"/>		\$150.00
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	92%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00

Options for Additional Benefit Design Limits:

a Maximum on Specialty Rx Coinsurance Payments?
Specialty Rx Coinsurance Maximum: \$750

Maximum Number of Days for Charging an IP Copay?
Days (1-10):

Primary Care Cost-Sharing After a Set Number of Visits?
Visits (1-10):

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
Copays (1-10):

Output

Calculate

Status/Error Messages: Calculation Successful.

Actuarial Value: 88.7%

Metal Tier: Platinum

This product, NY Platinum NYC Community PlansM \$30 satisfies the HHS guidelines for a Platinum plan with an Actuarial Value of 88.7%.

Summary of Benefits Covered

NY GOLD HEALTHY NY RE

New York Small Group

Gold Plan

Summary of Features In-Network

Deductible	
Individual	\$600
Family	\$1,200
Coinsurance <i>(Member Responsibility)</i>	20%
	<i>\$0 once out-of-pocket max. is satisfied</i>
Out-of-Pocket Maximum	
Individual	\$4,000
Family	\$8,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
Primary Care Visit to Treat an Injury or Illness <i>(excludes Preventative and X-rays)</i>	\$25 per visit after deductible
Specialist Visit	\$40 per visit after deductible
All Inpatient Hospital Services <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	\$1,000/Admit after deductible
Emergency Room Services	\$150 per visit after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$25 per visit after deductible
Imaging (CT/PET Scans, MRIs)	\$40 per visit after deductible
Rehabilitative Speech Therapy	\$30 per visit after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$30 per visit after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	\$40 per visit after deductible
X-rays and Diagnostic Imaging	\$40 per visit after deductible
Skilled Nursing Facility	\$1,000/Admit after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100 per visit after deductible
Outpatient Surgery Physician/Surgical Services	\$100 per visit after deductible

Pharmacy In-Network

Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	\$10 copay
Preferred Brand Drugs	\$35 copay
Non-Preferred Brand Drugs	\$70 copay
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

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

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSAs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$34.08	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	96%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages: Calculation Successful.
 Actuarial Value: 79.0%
 Metal Tier: Gold

This product, NY Gold Healthy NY RE, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79%.

Summary of Benefits Covered

NY PLATINUM NYC COMMUNITY PLANSM \$20 RE

New York Small Group

Platinum Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	N/A	
Family	N/A	
Coinsurance <i>(Member Responsibility)</i>	N/A	
	<i>\$0 once out-of-pocket max. is satisfied</i>	
Out-of-Pocket Maximum		
Individual	\$1,000	
Family	\$2,000	
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>	
Primary Care Visit to Treat an Injury or Illness <i>(excludes Preventative and X-rays)</i>	\$20 per visit	30% after deductible
Specialist Visit	\$35 per visit	30% after deductible
All Inpatient Hospital Services <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	\$500/Admit	30% after deductible
Emergency Room Services	\$100 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$35 per visit	30% after deductible
Imaging (CT/PET Scans, MRIs)	\$35 per visit	30% after deductible
Rehabilitative Speech Therapy	\$35 per visit	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$35 per visit	30% after deductible
Preventive Care/Screening/Immunization	0%	30% after deductible
Laboratory Outpatient and Professional Services	0%	30% after deductible
X-rays and Diagnostic Imaging	\$35 per visit	30% after deductible
Skilled Nursing Facility	\$500/Admit	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150 per visit	30% after deductible
Outpatient Surgery Physician/Surgical Services	0%	30% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	\$10 copay	
Preferred Brand Drugs	\$50 copay	
Non-Preferred Brand Drugs	50% up to \$750	
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?

Apply Inpatient Copay per Day?

Apply Skilled Nursing Facility Copay per Day?

Rate OOP Maximum for Medical and Drug Spending?

Indicate if Plan Meets CSR Standard?

Desired Metal Tier: Platin

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input checked="" type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	92%
		2nd Tier Utilization:	8%

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00	\$5,000.00	\$0.00	
Coinsurance (%; Insurer's Cost Share)	100.00%	50.00%	70.00%	50.00%	
OOP Maximum (\$)	\$1,000.00		\$5,250.00		
OOP Maximum if Separate (\$)	\$1,000.00	\$0.00			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00

Options for Additional Benefit Design Limits:

a Maximum on Specialty Rx Coinsurance Payments?
 Specialty Rx Coinsurance Maximum: \$750

Maximum Number of Days for Charging an IP Copay?
 # Days (1-10):

Primary Care Cost-Sharing After a Set Number of Visits?
 # Visits (1-10):

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
 # Copays (1-10):

Output

Calculate

Status/Error Messages: Calculation Successful.

Actuarial Value: 89.3%

Metal Tier: Platinum

This product, NY Platinum NYC Community PlansM \$20 RE satisfies the HHS guidelines for a Platinum plan with an Actuarial Value of 89.3%.

Summary of Benefits Covered

NY PLATINUM NYC COMMUNITY PLANSM \$30 RE

New York Small Group

Platinum Plan

Summary of Features		
	In-Network	Out-of-Network
Deductible		
Individual	N/A	
Family	N/A	
Coinsurance (Member Responsibility)	N/A	
	<i>\$0 once out-of-pocket max. is satisfied</i>	
Out-of-Pocket Maximum		
Individual	\$1,000	
Family	\$2,000	
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	\$30 per visit	30% after deductible
Specialist Visit	\$50 per visit	30% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	\$1,000/Admit	30% after deductible
Emergency Room Services	\$150 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$50 per visit	30% after deductible
Imaging (CT/PET Scans, MRIs)	\$50 per visit	30% after deductible
Rehabilitative Speech Therapy	\$50 per visit	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$50 per visit	30% after deductible
Preventive Care/Screening/Immunization	0%	30% after deductible
Laboratory Outpatient and Professional Services	0%	30% after deductible
X-rays and Diagnostic Imaging	\$50 per visit	30% after deductible
Skilled Nursing Facility	\$1,000/Admit	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150 per visit	30% after deductible
Outpatient Surgery Physician/Surgical Services	0%	30% after deductible
Pharmacy		
	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	\$10 copay	
Preferred Brand Drugs	\$50 copay	
Non-Preferred Brand Drugs	50% up to \$750	
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?

Apply Inpatient Copay per Day?

Apply Skilled Nursing Facility Copay per Day?

Rate OOP Maximum for Medical and Drug Spending?

Indicate if Plan Meets CSR Standard?

Desired Metal Tier: Platin

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input checked="" type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	92%
		2nd Tier Utilization:	8%

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00	\$5,000.00	\$0.00	
Coinsurance (% Insurer's Cost Share)	100.00%	50.00%	70.00%	50.00%	
OOP Maximum (\$)	\$1,000.00		\$5,250.00		
OOP Maximum if Separate (\$)	\$1,000.00	\$0.00			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input type="checkbox"/>	<input type="checkbox"/>		\$150.00
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	92%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00

Options for Additional Benefit Design Limits:

a Maximum on Specialty Rx Coinsurance Payments?
Specialty Rx Coinsurance Maximum: \$750

Maximum Number of Days for Charging an IP Copay?
Days (1-10):

Primary Care Cost-Sharing After a Set Number of Visits?
Visits (1-10):

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
Copays (1-10):

Output

Calculate

Status/Error Messages: Calculation Successful.

Actuarial Value: 88.7%

Metal Tier: Platinum

This product, NY Platinum NYC Community PlansM \$30 RE satisfies the HHS guidelines for a Platinum plan with an Actuarial Value of 88.7%.

Plan Relativity Factors

Table 1 - HMO

PPID	New Plan Name	Plan Relativity Factor	Rx Generic	Rx Brand Formulary	Rx Brand Non-Formulary	INN Coins	INN Deductible	INN OOP Max	Non-Designated Coins	Non-Designated Deductible	Non-Designated OOP Max	Primary Copay	Specialist Copay	SPU Copay	Hospital Copay	ER Copay
6414870	NYC Community Plan Platinum 30	0.964278	\$10	\$50	50% up to \$750	N/A	N/A	\$1,000	30%	\$5,000	\$5,250	\$30	\$50	100% Coins	\$1000 / admit	\$150
6414869	NYC Community Plan Platinum 20	1.000000	\$10	\$50	50% up to \$750	N/A	N/A	\$1,000	30%	\$5,000	\$5,250	\$20	\$35	100% Coins	\$500 / admit	\$100
14018914	NY Gold Healthy NY 600	1.166019	\$10	\$50	50% up to \$750	20%	\$600	\$4,000				\$25	\$40	\$100	\$1000 / admit	\$150
14018910	NYC Community Plan Platinum 30 RE	0.950027	\$10	\$50	50% up to \$750	N/A	N/A	\$1,000	\$0	\$5,000	\$5,250	\$30	\$50	100% Coins	\$1000 / admit	\$150
14018909	NYC Community Plan Platinum 20 RE	0.985222	\$10	\$50	50% up to \$750	N/A	N/A	\$1,000	\$0	\$5,000	\$5,250	\$20	\$35	100% Coins	\$500 / admit	\$100
14018911	NY Gold Healthy NY 600 RE	1.148787	\$10	\$50	50% up to \$750	20%	\$600	\$4,000				\$25	\$40	\$100	\$1000 / admit	\$150

**Aetna Health Inc.
New York Small Group**

Premium Rates

Monthly rates for effective dates January 1, 2014 through December 31, 2014 are shown in pages D-2 through D-33.

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA01

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		1Q 2014	1Q 2014	1Q 2014	1Q 2014	1Q 2014	1Q 2014
6414870	HMO	\$413	\$702	\$825	\$1,176	\$724	\$1,214
6414869	HMO	\$428	\$728	\$856	\$1,220	\$751	\$1,259
14018914	HMO	\$499	\$848	\$998	\$1,422	\$876	\$1,468
14018910	HMO	\$407	\$691	\$813	\$1,159	\$713	\$1,196
14018909	HMO	\$422	\$717	\$843	\$1,202	\$740	\$1,240
14018911	HMO	\$492	\$836	\$983	\$1,401	\$863	\$1,446

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA01

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014
6414870	HMO	\$422	\$717	\$844	\$1,203	\$740	\$1,241
6414869	HMO	\$438	\$744	\$875	\$1,247	\$768	\$1,287
14018914	HMO	\$510	\$867	\$1,020	\$1,454	\$895	\$1,501
14018910	HMO	\$416	\$707	\$831	\$1,185	\$729	\$1,223
14018909	HMO	\$431	\$733	\$862	\$1,229	\$756	\$1,268
14018911	HMO	\$503	\$855	\$1,005	\$1,433	\$882	\$1,478

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA01

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 3Q 2014	Child(ren) Premium Rate 3Q 2014	Premium Rate 3Q 2014	Premium Rate 3Q 2014	Child(ren) Premium Rate 3Q 2014	Premium Rate 3Q 2014
6414870	HMO	\$431	\$733	\$863	\$1,229	\$757	\$1,269
6414869	HMO	\$447	\$760	\$895	\$1,275	\$785	\$1,316
14018914	HMO	\$522	\$887	\$1,043	\$1,487	\$915	\$1,534
14018910	HMO	\$425	\$722	\$850	\$1,211	\$746	\$1,250
14018909	HMO	\$441	\$749	\$881	\$1,256	\$773	\$1,296
14018911	HMO	\$514	\$874	\$1,028	\$1,465	\$902	\$1,512

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA01

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Premium	Rate	Rate	Premium	Rate
		4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014
6414870	HMO	\$441	\$750	\$882	\$1,257	\$774	\$1,297
6414869	HMO	\$457	\$778	\$915	\$1,304	\$802	\$1,345
14018914	HMO	\$533	\$907	\$1,067	\$1,520	\$936	\$1,569
14018910	HMO	\$435	\$739	\$869	\$1,238	\$762	\$1,278
14018909	HMO	\$451	\$766	\$901	\$1,284	\$791	\$1,325
14018911	HMO	\$525	\$893	\$1,051	\$1,497	\$922	\$1,545

1Q 2014 Rate Summary

Rate Tables - Medical Plans
 NYRA02

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 1Q 2014	Child(ren) Premium Rate 1Q 2014	Premium Rate 1Q 2014	Premium Rate 1Q 2014	Child(ren) Premium Rate 1Q 2014	Premium Rate 1Q 2014
6414870	HMO	\$413	\$702	\$825	\$1,176	\$724	\$1,214
6414869	HMO	\$428	\$728	\$856	\$1,220	\$751	\$1,259
14018914	HMO	\$499	\$848	\$998	\$1,422	\$876	\$1,468
14018910	HMO	\$407	\$691	\$813	\$1,159	\$713	\$1,196
14018909	HMO	\$422	\$717	\$843	\$1,202	\$740	\$1,240
14018911	HMO	\$492	\$836	\$983	\$1,401	\$863	\$1,446

2Q 2014 Rate Summary

Rate Tables - Medical Plans
 NYRA02

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014
6414870	HMO	\$422	\$717	\$844	\$1,203	\$740	\$1,241
6414869	HMO	\$438	\$744	\$875	\$1,247	\$768	\$1,287
14018914	HMO	\$510	\$867	\$1,020	\$1,454	\$895	\$1,501
14018910	HMO	\$416	\$707	\$831	\$1,185	\$729	\$1,223
14018909	HMO	\$431	\$733	\$862	\$1,229	\$756	\$1,268
14018911	HMO	\$503	\$855	\$1,005	\$1,433	\$882	\$1,478

3Q 2014 Rate Summary

Rate Tables - Medical Plans
 NYRA02

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 3Q 2014	Child(ren) Premium Rate 3Q 2014	Premium Rate 3Q 2014	Premium Rate 3Q 2014	Child(ren) Premium Rate 3Q 2014	Premium Rate 3Q 2014
6414870	HMO	\$431	\$733	\$863	\$1,229	\$757	\$1,269
6414869	HMO	\$447	\$760	\$895	\$1,275	\$785	\$1,316
14018914	HMO	\$522	\$887	\$1,043	\$1,487	\$915	\$1,534
14018910	HMO	\$425	\$722	\$850	\$1,211	\$746	\$1,250
14018909	HMO	\$441	\$749	\$881	\$1,256	\$773	\$1,296
14018911	HMO	\$514	\$874	\$1,028	\$1,465	\$902	\$1,512

4Q 2014 Rate Summary

Rate Tables - Medical Plans
 NYRA02

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014
6414870	HMO	\$441	\$750	\$882	\$1,257	\$774	\$1,297
6414869	HMO	\$457	\$778	\$915	\$1,304	\$802	\$1,345
14018914	HMO	\$533	\$907	\$1,067	\$1,520	\$936	\$1,569
14018910	HMO	\$435	\$739	\$869	\$1,238	\$762	\$1,278
14018909	HMO	\$451	\$766	\$901	\$1,284	\$791	\$1,325
14018911	HMO	\$525	\$893	\$1,051	\$1,497	\$922	\$1,545

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA03

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 1Q 2014	Child(ren) Premium Rate 1Q 2014	Premium Rate 1Q 2014	Premium Rate 1Q 2014	Child(ren) Premium Rate 1Q 2014	Premium Rate 1Q 2014
6414870	HMO	\$456	\$776	\$913	\$1,301	\$801	\$1,342
6414869	HMO	\$473	\$805	\$947	\$1,349	\$830	\$1,392
14018914	HMO	\$552	\$938	\$1,104	\$1,573	\$968	\$1,623
14018910	HMO	\$450	\$764	\$899	\$1,281	\$789	\$1,322
14018909	HMO	\$466	\$793	\$933	\$1,329	\$818	\$1,371
14018911	HMO	\$544	\$924	\$1,087	\$1,550	\$954	\$1,599

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA03

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014
6414870	HMO	\$467	\$793	\$933	\$1,330	\$819	\$1,372
6414869	HMO	\$484	\$823	\$968	\$1,379	\$849	\$1,423
14018914	HMO	\$564	\$959	\$1,128	\$1,608	\$990	\$1,659
14018910	HMO	\$460	\$781	\$919	\$1,310	\$806	\$1,352
14018909	HMO	\$477	\$810	\$953	\$1,359	\$836	\$1,402
14018911	HMO	\$556	\$945	\$1,112	\$1,584	\$975	\$1,635

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA03

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		3Q 2014	3Q 2014	3Q 2014	3Q 2014	3Q 2014	3Q 2014
6414870	HMO	\$477	\$811	\$954	\$1,359	\$837	\$1,403
6414869	HMO	\$495	\$841	\$989	\$1,410	\$868	\$1,455
14018914	HMO	\$577	\$980	\$1,154	\$1,644	\$1,012	\$1,696
14018910	HMO	\$470	\$799	\$940	\$1,339	\$824	\$1,382
14018909	HMO	\$487	\$828	\$975	\$1,389	\$855	\$1,433
14018911	HMO	\$568	\$966	\$1,136	\$1,619	\$997	\$1,671

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA03

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Premium	Rate	Rate	Premium	Rate
		4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014
6414870	HMO	\$488	\$829	\$975	\$1,390	\$856	\$1,434
6414869	HMO	\$506	\$860	\$1,011	\$1,441	\$887	\$1,487
14018914	HMO	\$590	\$1,002	\$1,179	\$1,681	\$1,035	\$1,734
14018910	HMO	\$480	\$817	\$961	\$1,369	\$843	\$1,413
14018909	HMO	\$498	\$847	\$996	\$1,420	\$874	\$1,465
14018911	HMO	\$581	\$988	\$1,162	\$1,656	\$1,019	\$1,709

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA04

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		1Q 2014	1Q 2014	1Q 2014	1Q 2014	1Q 2014	1Q 2014
6414870	HMO	\$456	\$776	\$913	\$1,301	\$801	\$1,342
6414869	HMO	\$473	\$805	\$947	\$1,349	\$830	\$1,392
14018914	HMO	\$552	\$938	\$1,104	\$1,573	\$968	\$1,623
14018910	HMO	\$450	\$764	\$899	\$1,281	\$789	\$1,322
14018909	HMO	\$466	\$793	\$933	\$1,329	\$818	\$1,371
14018911	HMO	\$544	\$924	\$1,087	\$1,550	\$954	\$1,599

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA04

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014
6414870	HMO	\$467	\$793	\$933	\$1,330	\$819	\$1,372
6414869	HMO	\$484	\$823	\$968	\$1,379	\$849	\$1,423
14018914	HMO	\$564	\$959	\$1,128	\$1,608	\$990	\$1,659
14018910	HMO	\$460	\$781	\$919	\$1,310	\$806	\$1,352
14018909	HMO	\$477	\$810	\$953	\$1,359	\$836	\$1,402
14018911	HMO	\$556	\$945	\$1,112	\$1,584	\$975	\$1,635

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA04

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Premium	Rate	Rate	Premium	Rate
		3Q 2014	3Q 2014	3Q 2014	3Q 2014	3Q 2014	3Q 2014
6414870	HMO	\$477	\$811	\$954	\$1,359	\$837	\$1,403
6414869	HMO	\$495	\$841	\$989	\$1,410	\$868	\$1,455
14018914	HMO	\$577	\$980	\$1,154	\$1,644	\$1,012	\$1,696
14018910	HMO	\$470	\$799	\$940	\$1,339	\$824	\$1,382
14018909	HMO	\$487	\$828	\$975	\$1,389	\$855	\$1,433
14018911	HMO	\$568	\$966	\$1,136	\$1,619	\$997	\$1,671

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA04

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Premium	Rate	Rate	Premium	Rate
		4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014
6414870	HMO	\$488	\$829	\$975	\$1,390	\$856	\$1,434
6414869	HMO	\$506	\$860	\$1,011	\$1,441	\$887	\$1,487
14018914	HMO	\$590	\$1,002	\$1,179	\$1,681	\$1,035	\$1,734
14018910	HMO	\$480	\$817	\$961	\$1,369	\$843	\$1,413
14018909	HMO	\$498	\$847	\$996	\$1,420	\$874	\$1,465
14018911	HMO	\$581	\$988	\$1,162	\$1,656	\$1,019	\$1,709

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA05

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		1Q 2014	1Q 2014	1Q 2014	1Q 2014	1Q 2014	1Q 2014
6414870	HMO	\$413	\$702	\$825	\$1,176	\$724	\$1,214
6414869	HMO	\$428	\$728	\$856	\$1,220	\$751	\$1,259
14018914	HMO	\$499	\$848	\$998	\$1,422	\$876	\$1,468
14018910	HMO	\$407	\$691	\$813	\$1,159	\$713	\$1,196
14018909	HMO	\$422	\$717	\$843	\$1,202	\$740	\$1,240
14018911	HMO	\$492	\$836	\$983	\$1,401	\$863	\$1,446

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA05

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014
6414870	HMO	\$422	\$717	\$844	\$1,203	\$740	\$1,241
6414869	HMO	\$438	\$744	\$875	\$1,247	\$768	\$1,287
14018914	HMO	\$510	\$867	\$1,020	\$1,454	\$895	\$1,501
14018910	HMO	\$416	\$707	\$831	\$1,185	\$729	\$1,223
14018909	HMO	\$431	\$733	\$862	\$1,229	\$756	\$1,268
14018911	HMO	\$503	\$855	\$1,005	\$1,433	\$882	\$1,478

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA05

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 3Q 2014	Child(ren) Premium Rate 3Q 2014	Premium Rate 3Q 2014	Premium Rate 3Q 2014	Child(ren) Premium Rate 3Q 2014	Premium Rate 3Q 2014
6414870	HMO	\$431	\$733	\$863	\$1,229	\$757	\$1,269
6414869	HMO	\$447	\$760	\$895	\$1,275	\$785	\$1,316
14018914	HMO	\$522	\$887	\$1,043	\$1,487	\$915	\$1,534
14018910	HMO	\$425	\$722	\$850	\$1,211	\$746	\$1,250
14018909	HMO	\$441	\$749	\$881	\$1,256	\$773	\$1,296
14018911	HMO	\$514	\$874	\$1,028	\$1,465	\$902	\$1,512

4Q 2014 Rate Summary

Rate Tables - Medical Plans
NYRA05

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 4Q 2014	Child(ren) Premium Rate 4Q 2014	Premium Rate 4Q 2014	Premium Rate 4Q 2014	Child(ren) Premium Rate 4Q 2014	Premium Rate 4Q 2014
6414870	HMO	\$441	\$750	\$882	\$1,257	\$774	\$1,297
6414869	HMO	\$457	\$778	\$915	\$1,304	\$802	\$1,345
14018914	HMO	\$533	\$907	\$1,067	\$1,520	\$936	\$1,569
14018910	HMO	\$435	\$739	\$869	\$1,238	\$762	\$1,278
14018909	HMO	\$451	\$766	\$901	\$1,284	\$791	\$1,325
14018911	HMO	\$525	\$893	\$1,051	\$1,497	\$922	\$1,545

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA06

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		1Q 2014	1Q 2014	1Q 2014	1Q 2014	1Q 2014	1Q 2014
6414870	HMO	\$413	\$702	\$825	\$1,176	\$724	\$1,214
6414869	HMO	\$428	\$728	\$856	\$1,220	\$751	\$1,259
14018914	HMO	\$499	\$848	\$998	\$1,422	\$876	\$1,468
14018910	HMO	\$407	\$691	\$813	\$1,159	\$713	\$1,196
14018909	HMO	\$422	\$717	\$843	\$1,202	\$740	\$1,240
14018911	HMO	\$492	\$836	\$983	\$1,401	\$863	\$1,446

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA06

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014
6414870	HMO	\$422	\$717	\$844	\$1,203	\$740	\$1,241
6414869	HMO	\$438	\$744	\$875	\$1,247	\$768	\$1,287
14018914	HMO	\$510	\$867	\$1,020	\$1,454	\$895	\$1,501
14018910	HMO	\$416	\$707	\$831	\$1,185	\$729	\$1,223
14018909	HMO	\$431	\$733	\$862	\$1,229	\$756	\$1,268
14018911	HMO	\$503	\$855	\$1,005	\$1,433	\$882	\$1,478

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA06

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Premium	Rate	Rate	Premium	Rate
		3Q 2014	3Q 2014	3Q 2014	3Q 2014	3Q 2014	3Q 2014
6414870	HMO	\$431	\$733	\$863	\$1,229	\$757	\$1,269
6414869	HMO	\$447	\$760	\$895	\$1,275	\$785	\$1,316
14018914	HMO	\$522	\$887	\$1,043	\$1,487	\$915	\$1,534
14018910	HMO	\$425	\$722	\$850	\$1,211	\$746	\$1,250
14018909	HMO	\$441	\$749	\$881	\$1,256	\$773	\$1,296
14018911	HMO	\$514	\$874	\$1,028	\$1,465	\$902	\$1,512

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA06

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Premium	Rate	Rate	Premium	Rate
		4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014
6414870	HMO	\$441	\$750	\$882	\$1,257	\$774	\$1,297
6414869	HMO	\$457	\$778	\$915	\$1,304	\$802	\$1,345
14018914	HMO	\$533	\$907	\$1,067	\$1,520	\$936	\$1,569
14018910	HMO	\$435	\$739	\$869	\$1,238	\$762	\$1,278
14018909	HMO	\$451	\$766	\$901	\$1,284	\$791	\$1,325
14018911	HMO	\$525	\$893	\$1,051	\$1,497	\$922	\$1,545

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA07

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 1Q 2014	Child(ren) Premium Rate 1Q 2014	Premium Rate 1Q 2014	Premium Rate 1Q 2014	Child(ren) Premium Rate 1Q 2014	Premium Rate 1Q 2014
6414870	HMO	\$413	\$702	\$825	\$1,176	\$724	\$1,214
6414869	HMO	\$428	\$728	\$856	\$1,220	\$751	\$1,259
14018914	HMO	\$499	\$848	\$998	\$1,422	\$876	\$1,468
14018910	HMO	\$407	\$691	\$813	\$1,159	\$713	\$1,196
14018909	HMO	\$422	\$717	\$843	\$1,202	\$740	\$1,240
14018911	HMO	\$492	\$836	\$983	\$1,401	\$863	\$1,446

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA07

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014
6414870	HMO	\$422	\$717	\$844	\$1,203	\$740	\$1,241
6414869	HMO	\$438	\$744	\$875	\$1,247	\$768	\$1,287
14018914	HMO	\$510	\$867	\$1,020	\$1,454	\$895	\$1,501
14018910	HMO	\$416	\$707	\$831	\$1,185	\$729	\$1,223
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14018911	HMO	\$503	\$855	\$1,005	\$1,433	\$882	\$1,478

3Q 2014 Rate Summary

Rate Tables - Medical Plans
NYRA07

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 3Q 2014	Child(ren) Premium Rate 3Q 2014	Premium Rate 3Q 2014	Premium Rate 3Q 2014	Child(ren) Premium Rate 3Q 2014	Premium Rate 3Q 2014
6414870	HMO	\$431	\$733	\$863	\$1,229	\$757	\$1,269
6414869	HMO	\$447	\$760	\$895	\$1,275	\$785	\$1,316
14018914	HMO	\$522	\$887	\$1,043	\$1,487	\$915	\$1,534
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14018911	HMO	\$514	\$874	\$1,028	\$1,465	\$902	\$1,512

4Q 2014 Rate Summary

Rate Tables - Medical Plans
NYRA07

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 4Q 2014	Child(ren) Premium Rate 4Q 2014	Premium Rate 4Q 2014	Premium Rate 4Q 2014	Child(ren) Premium Rate 4Q 2014	Premium Rate 4Q 2014
6414870	HMO	\$441	\$750	\$882	\$1,257	\$774	\$1,297
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14018914	HMO	\$533	\$907	\$1,067	\$1,520	\$936	\$1,569
14018910	HMO	\$435	\$739	\$869	\$1,238	\$762	\$1,278
14018909	HMO	\$451	\$766	\$901	\$1,284	\$791	\$1,325
14018911	HMO	\$525	\$893	\$1,051	\$1,497	\$922	\$1,545

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA08

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium Rate 1Q 2014	Child(ren) Premium Rate 1Q 2014	Premium Rate 1Q 2014	Premium Rate 1Q 2014	Child(ren) Premium Rate 1Q 2014	Premium Rate 1Q 2014
6414870	HMO	\$456	\$776	\$913	\$1,301	\$801	\$1,342
6414869	HMO	\$473	\$805	\$947	\$1,349	\$830	\$1,392
14018914	HMO	\$552	\$938	\$1,104	\$1,573	\$968	\$1,623
14018910	HMO	\$450	\$764	\$899	\$1,281	\$789	\$1,322
14018909	HMO	\$466	\$793	\$933	\$1,329	\$818	\$1,371
14018911	HMO	\$544	\$924	\$1,087	\$1,550	\$954	\$1,599

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA08

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Rate	Rate	Rate	Rate	Rate
		2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014	2Q 2014
6414870	HMO	\$467	\$793	\$933	\$1,330	\$819	\$1,372
6414869	HMO	\$484	\$823	\$968	\$1,379	\$849	\$1,423
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14018910	HMO	\$460	\$781	\$919	\$1,310	\$806	\$1,352
14018909	HMO	\$477	\$810	\$953	\$1,359	\$836	\$1,402
14018911	HMO	\$556	\$945	\$1,112	\$1,584	\$975	\$1,635

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA08

With dependent up to
 age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Premium	Rate	Rate	Premium	Rate
		3Q 2014	3Q 2014	3Q 2014	3Q 2014	3Q 2014	3Q 2014
6414870	HMO	\$477	\$811	\$954	\$1,359	\$837	\$1,403
6414869	HMO	\$495	\$841	\$989	\$1,410	\$868	\$1,455
14018914	HMO	\$577	\$980	\$1,154	\$1,644	\$1,012	\$1,696
14018910	HMO	\$470	\$799	\$940	\$1,339	\$824	\$1,382
14018909	HMO	\$487	\$828	\$975	\$1,389	\$855	\$1,433
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4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA08

With dependent up to
age 30 rider

New Plan Number	Plan	Single	Parent &	Couple	Family	Parent &	Family
		Premium	Child(ren)	Premium	Premium	Child(ren)	Premium
		Rate	Premium	Rate	Rate	Premium	Rate
		4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014	4Q 2014
6414870	HMO	\$488	\$829	\$975	\$1,390	\$856	\$1,434
6414869	HMO	\$506	\$860	\$1,011	\$1,441	\$887	\$1,487
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14018910	HMO	\$480	\$817	\$961	\$1,369	\$843	\$1,413
14018909	HMO	\$498	\$847	\$996	\$1,420	\$874	\$1,465
14018911	HMO	\$581	\$988	\$1,162	\$1,656	\$1,019	\$1,709

List of Small Group Off-Exchange Forms

Healthy New York

OffHIXHNYGR-96816,
OffHIXHNYGR-96816-Contra Rider
OffHIXHNYGR-96816-SB
OffHIXHNYGR-96816-DepsAge 29
HMO/NY HEALTHY HCRSBC-1
HMO/NY HEALTHY- PREMIUMS

Small Group NYCCP – HMO

OffHIXSGNYCCPHMOGR-96821
OffHIXSGNYCCPHMOGR-96821-Contra Rider
OffHIXSGNYCCPHMOGR-96821-Deps Age 29
OffHIXSG(HMONYCCPSM\$20)GR-96821-SB
OffHIXSG(HMONYCCPSM\$30)GR-96821-SB

Exhibit A

**Average Anticipated Loss Ratios for Medical Coverage
Pricing Components Shown as a Percentage of Premium**

New York Employer Groups with Fewer than <u>50 Employees</u>	
Incurred Claims	83.4%
General Expenses	6.7%
ACA Taxes and Fees	3.7%
Premium Taxes	1.9%
Commissions	2.3%
FIT + Profit	2.0%
Total	100.0%
After FIT Profit	1.3%

FIT = Federal Income Tax

Loss Ratio for Small Group Coverages

The AHI small group HMO product's projected loss ratio for customers with rate increases effective for the 4 quarters provided in this filing (1Q2014-4Q2014) would be 83.4%. This reflects actual membership, premium, and claim experience since our submitted plan as well as adjustments for lapses and buy-downs per our plan. Note that we expect the loss ratio for calendar year 2014 to be in excess of the 82% statutory minimum. The claim trend assumption underlying this analysis is 10.3%.

The administrative expense assumptions underlying this analysis are approximately 14.6%, comprised of 2.3% for commissions, 1.9% for premium taxes with the remaining 10.4% for other selling and general administrative expenses including 3.7% to cover ACA related taxes and fees (RC and HIF), details of these taxes and fees are discussed in actuarial memorandum.

Exhibit B
Outline of General Underwriting and Marketing Methods

Aetna Health Inc. (New York), headquartered in Uniondale, New York, is licensed as a Health Maintenance Organization (HMO) pursuant to Article 44 of the New York State Public Health Law.

Aetna Health Inc. has approximately 13,543 total small group members including Healthy NY membership.

Aetna Health Inc. offers its comprehensive health care benefits, to the residents of the Greater New York counties of: New York, Queens, Kings, Bronx, Suffolk, Nassau, Westchester, Putnam, Orange, Rockland, Richmond, Dutchess, Ulster and Sullivan; the Syracuse counties of: Onondaga, Oswego, and Cayuga; and the Binghamton counties of: Broome and Tioga.

Aetna Health Inc. is an Individual Practice (IPA) model HMO that contracts with independent primary care physicians and specialists as well as with hospitals and ancillary providers.

Aetna Health Inc. offers traditional community rated contracts to employer groups, with no preexisting condition limitations or benefit waiting periods. Aetna Health Inc. makes available to these groups only those products and rates filed and approved, and compliant with all insurance laws, regulations and practices in the state of New York.

**Exhibit C
Commissions Schedule and Incentive Fees**

The commission schedule for 2014 has not been finalized. We currently estimated commissions to be at 2.3% of premium. We will make the appropriate adjustments once the commission schedule is finalized.

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Major Medical and Other Similar-Type Comprehensive Health Insurance for Small Groups
NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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”.

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		(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 March 16, 2007 , submission number 2005100113 .	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: <ul style="list-style-type: none"> • 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. 	
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: <ul style="list-style-type: none"> • 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 policy or contract form, the letter must identify the form number and 	

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		<p>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)</p> <ul style="list-style-type: none"> • 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) • <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.</i> 	
<p>Group Status and Recognition</p>	<p>§ 4235(c)(1)(A) §3201(b)(1) 11 NYCRR 59</p>	<p>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.</p> <p>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.</p> <p>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.</p>	
<p>Prefiled Group Coverage</p>	<p>11 NYCRR 52.32</p>	<p>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:</p> <ul style="list-style-type: none"> • 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 	

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		<p>approval by the Department. §52.32(a)(3)</p> <ul style="list-style-type: none"> 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) <p><i>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.</i></p>	
<p>Statement of ERISA rights</p> <p>Is the insurer providing document as the plan administrator or for the plan administrator? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)</p>	<p>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.</p>	
<p>APPLICATION FORMS</p> <p>Model Application Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>		<p>Form/Page/Para Reference</p>
<p>Authorization</p>	<p>11 NYCRR 420.18(b)</p>	<p>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.</p>	
<p>Fraud Warning Statement</p>	<p>§403(d) 11 NYCRR 86.4</p>	<p>The application contains the prescribed fraud warning statement immediately above the insured's signature.</p>	
<p>Prohibited Questions and Provisions</p>	<p>§3221(q)(1) §3204 11 NYCRR 52.51</p>	<p>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).</p>	
<p>Verification of Compliance with Pediatric Essential Dental Health Benefit.</p>	<p>45 CFR § 156.150</p>	<p>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:</p>	

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		<p>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</p> <p>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.</p>	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Yes
Table of Contents Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 3217 Model Language	A table of contents is required.	
DEFINITIONS Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 3217 Model Language	<i>For a complete listing of the definitions click on the adjacent Model Language link.</i>	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.	
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Designation of Primary Care	§3217-e	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract	

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<p>Provider (PCP) & Access to Pediatrics</p> <p>Does this product require a PCP to be designated? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language</p>	<p>form permits an insured to designate any participating PCP who is available to accept the insured.</p> <p>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.</p>	
<p>Direct Access to OB/GYN Services</p> <p>Does this product require a PCP to be designated? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§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</p>	<p>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:</p> <ul style="list-style-type: none"> • 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. 	
Preauthorization			
<p>Preauthorization Requirements</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b) Model Language</p>	<p>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.</p>	
Medical Necessity			
<p>Definition of Medical Necessity</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(1) §4324(a)(1) Model Language</p>	<p>This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.</p>	
<p>Contact Information</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(16) §4324(a)(16) PHL §4408(1)(q) Model Language</p>	<p>This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.</p>	
ACCESS TO CARE AND TRANSITIONAL CARE			
<p>Referral to Non-Participating Providers</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) Model Language</p>	<p>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</p>	

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		insured can obtain such referral.	
Specialty Care Provider as PCP Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Standing Referrals Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Specialty Care Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Transitional Care When A Provider Leaves the Network Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4804(e) §3217-d(c) §4306-C(c) PHL §4403(6)(e) Model Language	<p>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.</p> <p>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.</p>	
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	<p>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.</p> <p>In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the</p>	

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		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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Reimbursement of Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
ELIGIBILITY Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
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. <i>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.</i>	

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<p>Extended Dependent Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4235(f)(1)(B) §4305(c)(1)</p> <p>Model Language</p>	<p>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.</p> <p>The company must comply with the notice requirements set forth in 4235(f).</p>	
<p>Unmarried Students on Medical Leave of Absence</p>	<p>§3237 §4306-a</p> <p>42 USC §300gg-7</p>	<p>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.</p>	
<p>Unmarried Disabled Children</p>	<p>§4235(f)(1)(A)(ii) §4305(c)(1) Model Language</p>	<p>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.</p> <p><i>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.</i></p>	
<p>Newborn Infants</p>	<p>§4235(f)(2) §4305(c)(1) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725</p>	<p>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.</p> <p><i>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.</i></p>	
<p>Adopted Children and Step-Children</p>	<p>11NYCRR52.18(e)(2)); (3) §4305(c)(1)</p>	<p>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</p>	

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		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: <ul style="list-style-type: none"> • 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. 	
New Family Members Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
New Employees	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	
Enrollment Periods	http://government.westlaw.com/linkedslice/default.asp?SP=nycr 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.	
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

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		<p>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.</p> <p>The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative</p>	
PREVENTIVE CARE			
<p>Primary and Preventive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§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</p>	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Federal Mandated Preventive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing:</p> <ul style="list-style-type: none"> • 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. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Cervical Cytology Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>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.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	
<p>Mammography Screening</p>	<p>§ 3221(l)(11) § 4303(p)</p>	<p>This policy or contract form includes the following coverage for mammography screening for occult breast cancer:</p>	

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<ul style="list-style-type: none"> • 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. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	
<p>Family Planning & Reproductive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines</p>	<p>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.</p> <p>This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Bone Mineral Density Measurements or Tests, Drugs and Devices</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language</p>	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>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</p>	
<p>Prostate Cancer Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(11-a) § 4303(z-1) Model Language</p>	<p>This policy or contract form includes coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • 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 	

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		<ul style="list-style-type: none"> 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. <p>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.</p>	
EMERGENCY SERVICES AND URGENT CARE			
<p>Pre-Hospital Emergency Medical and Ambulance Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(15) § 4303(aa) Model Language</p>	<p><u>Emergency Medical and Ambulance Services:</u> 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.</p> <p>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.</p> <p><u>Non-Emergency Ambulance Services:</u> 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:</p> <ul style="list-style-type: none"> 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. 	
<p>Emergency Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1</p>	<p>This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities:</p> <ul style="list-style-type: none"> 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 	

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	<p>(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</p>	<p>that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers;</p> <ul style="list-style-type: none"> • 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. <p><i>Note the following definitions must be used:</i> <i>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.</i></p> <p><i>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).</i></p>	
<p>Urgent Care Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100</p>	<p>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.</p>	
<p>OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES</p>			
<p>Advanced Imaging</p>	<p>45 CFR § 156.100</p>	<p>This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT</p>	

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Allergy Testing and Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Ambulatory Surgery Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Chemotherapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Chiropractic Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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. <i>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.</i>	
Dialysis Coverage	§3221(k)(16) §4303(gg)	This policy or contract form provides coverage for dialysis treatment of an acute or chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis	

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>treatment or services provided by a non-participating provider must be covered if the following conditions are met:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	
<p>Outpatient Habilitative Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.</p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	

Benefit explanation:

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<p>Home Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(1) §4303(a)(3) Model Language</p>	<p>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:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	
<p>Interruption of Pregnancy</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p><i>Note: Plans must include the one procedure limit and may provide coverage that is more favorable.</i></p>	
<p>Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(6) 4303(s) 11 NYCRR 52.18(a)(10) Definition of Infertility OGC Opinion 05-11-10 Model Language</p>	<p>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.</p> <ul style="list-style-type: none"> • 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; 	

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		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.	
<p>Infusion Therapy</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Laboratory Procedures, Diagnostic Testing and Radiology Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Office Visits</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Outpatient Hospital Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Preadmission Testing</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(2) §4303(a)(1) Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Outpatient Rehabilitative Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p><i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i></p> <p>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</p>	

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<p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.</p>		<p>undergone surgery for such illness or injury.</p> <p>Speech, physical and occupational therapy services must begin within six months of the later to occur:</p> <ul style="list-style-type: none"> • 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. <p>In no event will the therapy continue beyond 365 days after such event.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>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.</i></p>	
<p><u>Benefit explanation:</u></p>			
<p>Second Medical Opinion for Cancer Diagnosis</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(9) §4303(w) Model Language</p>	<p>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.</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	
<p>Second Surgical Opinion</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(3) 4303(b) Circular Letter No. 29 (1979) Model Language</p>	<p>This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Mandatory Second Surgical Opinion</p>	<p>§3221(k)(3) 4303(b)</p>	<p>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).</p>	

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Circular Letter No. 29 (1979) Model Language</p>	<p>Such coverage may not be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Second Opinion in Other Cases Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p>	
<p>Surgical Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 11 NYCRR § 52.6 Model Language</p>	<p>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.</p>	
<p>Oral Surgery Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 11 NYCRR § 52.16(c)(9) Model Language</p>	<p>This policy or contract form provides coverage for the following limited dental and oral surgical procedures:</p> <ul style="list-style-type: none"> • 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. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Mastectomy Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(8) §4303(v) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>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.</p>	
<p>Post Mastectomy Reconstruction</p>	<p>§3221(k)(10) §4303(x) Women’s Health and</p>	<p>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</p>	

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>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.</p>	
<p>Transplants Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Autism Spectrum Disorder Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(l)(17) §4303(ee) Model Language 11 NYCRR 440</p>	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>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).</p> <p>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.</p> <p>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.</p>	

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		<p>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.</p> <p>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.</p>	
<p>Diabetes Equipment, Supplies and Self-Management Education</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(7) §4303(u) 10NYCRR60-3.1 Model Language</p>	<p>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.</p> <p><i>Note: Plans may apply either a medical or a prescription benefit depending upon whichever will provide a more generous benefit.</i></p> <p><i>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.</i></p>	
<p>Durable Medical Equipment and Braces</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Hearing Aids</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>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. <i>{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.}</i></p> <p>Bone anchored hearing aids must be covered only if an insured has either of the following:</p> <ul style="list-style-type: none"> • 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. <p>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</p>	

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		<p>malfunctions. <i>{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.}</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Hospice Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(d)(10) §4303(o) 45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p><i>Note: A plan must cover 210 days of hospice care; however plans can cover more than 210 days.</i></p>	
<p>Prosthetics</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p><i>Note: The limit on prosthetic devices is required for plans, but the limit may be removed or modified so that coverage is more favorable.</i></p> <p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	

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<p>Hospital Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.5 45 CFR § 156.100 Model Language</p>	<p>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:</p> <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic 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. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Maternity Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(5) 4303(c) Model Language</p>	<p>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.</p> <p>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.</p> <p>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.</p>	

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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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Inpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 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. <i>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.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i>	
<u>Benefit explanation:</u>			
Skilled Nursing Facility Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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. <i>Note: Plans must cover 200 days, but may cover more than 200 days.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance.	
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.	

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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language		
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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. <i>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.</i>	
Outpatient Mental Health Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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. <i>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</i>	

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<p>Inpatient Substance Use Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§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</p>	<p><i>treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p> <p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>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.</i></p>	
<p>Outpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§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</p>	<p>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.</p> <p>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.</p>	

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		<p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>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.</i></p> <p><i>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.</i></p>	
PRESCRIPTION DRUGS			
<p>Prescription Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>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.</p>	
<p>Enteral Formulas</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(11) §4303(y) OGC Opinion 10-12-03 Model Language</p>	<p>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</p>	

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		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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
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).	
Eye Drops Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Orally Administered Anticancer Medications Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Mail Order Drugs for Policies With a Provider Network Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
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	

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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		must be provided with no cost-sharing. <i>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.</i>	
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <i>Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.</i> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 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. <i>Note: Plans may offer more comprehensive coverage or may substitute this benefit.</i>	
<u>Benefit explanation:</u>			
Other Wellness Benefits	45 CFR § 156.100 §3239	Additional Wellness Benefits may be covered. All additional wellness benefits <u>must</u> comply with § 3239 of Insurance Law.	
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,	

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
DENTAL CARE			
<p>Pediatric Dental Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is dental coverage being provided by the insurer in this filing? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>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.</p>	<p>45 CFR § 156.100 45 CFR § 156.150</p> <p>Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>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).</i></p> <p><i>Embedded pediatric dental benefits must comply with all of the market reform and rating rules such as 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.</i></p> <p><i>If the insurer offers a bundled stand-alone pediatric dental benefit, the following conditions must all be met:</i></p> <ul style="list-style-type: none"> • <i>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;</i> • <i>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;</i> • <i>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;</i> • <i>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.</i> • <i>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);</i> 	

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		<ul style="list-style-type: none"> • <i>The stand alone dental plan complies with all ACA provisions and CMS regulations pertaining to stand alone dental plans;</i> • <i>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.</i> <p><i>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</i></p>	
<p><u>Explanation:</u></p>			
ADDITIONAL BENEFITS			
<p>Family Vision</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p>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.</p>	
<p>Orthotics</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p>	
<p>Additional Benefits Provided In Policy or Contract, or By Rider</p> <p>Additional Benefits Provided? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If additional benefits are provided, please explain in box below.</p>	<p>http://public.leginfo.state.ny.us/menusetf.cgi?COMMONQUER Y=LAWS11 NYCRR 52.1(c)</p>	<p>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.</p>	
<p><u>Explanation:</u></p>			

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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(1)(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.	
Licensed Clinical Social Worker	§ 3221(1)(4) § 4303(i)	If this policy or 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.).	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>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.</i> <i>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.</i>	Form/Page/Para Reference
Aviation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Convalescent and Custodial Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Cosmetic Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
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 <input checked="" type="checkbox"/> No <input type="checkbox"/>) 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.	
Experimental or Investigational Treatment. Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Felony Participation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Foot Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Government Facility Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Medically Necessary Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Medicare or Other Governmental Program Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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).	
Military Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
No-Fault Automobile Insurance Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	

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Services Separately Billed by Hospital Employees Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Services Provided by a Family Member Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Services With No Charge Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	
Services not Listed Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Vision Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Workers' Compensation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
War Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Submission of Claim Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	

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GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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: <ul style="list-style-type: none"> • 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. 	
Utilization Review Policies and Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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: <ul style="list-style-type: none"> • 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. 	
External Appeal Procedures Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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: <ul style="list-style-type: none"> • 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. 	

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<p>COORDINATION OF BENEFITS</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.23 Model Language</p>	<p>If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.</p>	<p>Form/Page/Para Reference</p>
<p>TERMINATION OF COVERAGE</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p><i>The following are the only termination provisions permissible under the Insurance Law.</i></p>	<p>Form/Page/Para Reference</p>
<p>Notice of Termination</p>	<p>11 NYCRR 52.18(c)</p>	<p>Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.</p>	
<p>Termination for Failure to Pay Premiums</p>	<p>§3221(p)(2)(A) §4305(j)(2)(A)</p>	<p>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.</p>	
<p>Termination for Fraud</p>	<p>§3221(p)(2)(B) §4305(j)(2)(B) §3105</p>	<p>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.</p>	
<p>Termination for Failure to Comply With a Material Plan Provision</p>	<p>§3221(p)(2)(C) §4305(j)(2)(C)</p>	<p>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.</p>	
<p>Discontinuation of a Class of Coverage</p>	<p>§3221(p)(2)(D); §3221(p)(3)(A) §4305(j)(2)(D) §4305(j)(3)(A)</p>	<p>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.</p>	
<p>Discontinuation of all Policies/Contracts in the Small Market</p>	<p>§3221(p)(2)(D); §3221(p)(3)(B) §4305(j)(2)(D) §4305(j)(3)(B)</p>	<p>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.</p>	
<p>Termination for Failure to Meet Requirements of Group</p>	<p>§3221(p)(2)(E); §4235(c)(1) §4305(j)(2)(E)</p>	<p>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.</p>	
<p>Termination if there are No Longer Insureds in the Insurer's Service Area</p>	<p>§3221(p)(2)(F) §4305(j)(2)(F)</p>	<p>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.</p>	
<p>Termination for Spouses in cases of divorce</p>		<p>This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.</p>	

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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.	
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.	
Rescission Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
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.	
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.	
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Continuation Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	

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		<p>The continuation benefits terminate:</p> <ul style="list-style-type: none"> • 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. 	
<p>Young Adult Option Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(r) §4305(l) Model Language</p>	<p>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.</p> <p>The insurer must comply with the notice requirements to each employee or member as set forth in 3221(r), and/or 4305(l).</p>	
<p>Suspension of Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language</p>	<p>This policy or contract form provides that:</p> <ul style="list-style-type: none"> • 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. 	
<p>Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard</p>	<p>§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) Model Language</p>	<p>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.</p>	

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Conversion - Right to a New Contract After Termination Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(e) §4303(d)	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Changes Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Action in Law or Equity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Subrogation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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).	

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	Model Language		
Unilateral Modification Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	
Non-English Speaking Insureds Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
SCHEDULE OF BENEFITS Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
Limitations on Annual Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	
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.	
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 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. <i>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.</i>	N/A

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Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract <input type="checkbox"/> Rider <input type="checkbox"/>			N/A
Extended Dependent Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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).	
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.	
<p>PROVIDER NETWORKS</p> <p>Has network been submitted to and/or approved by the Department of Health or the Exchange? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>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.</p> <p>Network Name:</p> <p>Network ID #:</p> <p>Date Submitted:</p> <p>Date Approved:</p>	§3201(c)	<p>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.</p> <p>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 .</p> <p>In addition, the following items or information must be submitted as part of this filing:</p> <ul style="list-style-type: none"> • 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. <p><i>Note: The Department will not permit more than a 30% differential between in-network and out-of-</i></p>	

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		<i>network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i>	
ACTUARIAL SECTION FOR <u>NEW PRODUCT</u> RATE FILINGS ONLY		<p>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.</p> <p><i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i> <p><i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i></p>	
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 83.4 %.	Supporting Documentation: NY SG AHI Act Memo.pdf
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	AHI Rate Manual - Section F
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
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.	Supporting Documentation: NY SG AHI Act Memo.pdf
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: 83.4 %.	AHI Rate Manual - Section F

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<p>GROUP RATE MANUAL</p>	<p>11NYCRR52.40(e)(2) §3231(e)(1)(B) §4308(c)(3)(A)</p>	<p>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).</p>	
<p>ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY</p>		<p><i>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.)</i></p>	
<p>ACTUARIAL MEMORANDUM</p>	<p>11NYCRR52.40(a)(1) </p>	<p>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.</p>	
<p>Justification of Rates</p>	<p>11NYCRR52.40(e)</p>	<p>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.</p>	
<p>Actuarial Certification</p>	<p>11NYCRR52.40(a)(1) </p>	<p>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.</p>	
<p>Expected Loss Ratio Certification</p>	<p>§3231(e)(1)(B) §4308(c)(3)(A)</p>	<p>The expected loss ratio is: <input type="text"/> %.</p>	
<p>REVISED RATE MANUAL PAGES</p>	<p>11NYCRR52.40(e)(2) </p>	<p>a. Table of contents. b. Rate pages.</p>	

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		<ul style="list-style-type: none">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).	
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Name of Company Aetna Health Inc.

This is to certify that the form(s) listed on the attached page are in compliance with New York's 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 score is _____.
- 2. Policy and Certificate insert pages 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 insert page.
- 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed containing word samples tested.

C. Standard of Certification

A checked block indicates the standard has been achieved

- 1. The policy test achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.
- 2. It is printed in no less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables).
- 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
- 4. The section titles are captioned in bold face or otherwise stand out significantly from the text.
- 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
- 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
- 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)



Officer's Name

Product & Regulatory Approvals Sr. Manager

Officer's Title

Date May 14, 2013

SWH/al

Aetna Health Inc.

<u>Form #</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables</u>	<u>Flesch Score</u>
OffHIXHNYGR-96816				33.7*
OffHIXHNYGR-96816-Contra Rider				31.7*
OffHIXHNYGR-96816-DepsAge 29				51.8
HMO/NY HEALTHY HCRSBC-1				23.9**
HMO/NY HEALTHY-PREMIUMS				82.1
OffHIXSGNYCCPHMOGR-96821				33.7*
OffHIXSGNYCCPHMOGR-96821-Contra Rider				31.7*
OffHIXSGNYCCPHMOGR-96821-Deps Age 29				51.8

* We request that a Flesch Score lower than 45.0 be permitted, pursuant to Insurance Law Section 3102(d), inasmuch as the Policy forms enclosed use the Department's Model Language.

**When this form is included with a contract issued in New York, the combined score of the form and the contract will not be less than 45.0.

Aetna Health, Inc.
Actuarial Memorandum
Filing # [AETN-128992632]
Comprehensive Small Group Medical Expense Benefit Plans

Purpose, Scope and Proposed Effective Date

The purpose of this actuarial memorandum and filing is to request approval of monthly premium rates for Small Group of Aetna Health Inc. New York to use beginning January 1, 2014. The requested rates have been developed incorporating consideration of the market changes and rating requirements taking effect in the Small Group marketplace pursuant to the Patient Protection and Affordable Care Act of 2010 and subsequent regulation. The rates are compliant with all rating limitations under federal and state regulation. The plan designs contained in this submission are to be sold off the Exchange.

The descriptions and analyses presented in this rate filing reflect our understanding of regulations and guidance issued prior to May 15, 2013. As further guidance is received, we reserve the right to submit revisions or withdraw this rate filing.

Benefit Design

This filing covers HMO group medical benefit coverage. The range of coverage includes inpatient, outpatient, primary care, specialist services, pharmacy, DME, and vision. Please refer to the referenced policy forms listed in the Premium Rate Manual – Section E for detailed benefit language. Information on the cost-sharing parameters of the covered benefit plans, including deductibles and copays, can be found in the Premium Rate Manual – Section B. All benefits are compliant with state mandates and the requirements of the Patient Protection and Affordable Care Act of 2010, including preventive care benefits, deductible limits, and Actuarial Value requirements.

The Premium Rate Manual included in this rate filing contains worksheets and instructions for calculating the premium rates for the benefit plans available from Aetna Health, Inc. New York.

Applicability

These rates are intended for new business and mapped non-grandfathered renewal business beginning 1/1/2014.

Renewability Clause

This policy is guaranteed renewable as required under §2703 of the Public Health Service Act.

Determination of Claim Portion of Market Index Rate

In setting the projected claim level in the market in 2014, we based our projections upon the experience of our current small group block of Aetna Health, Inc. business in NY, including small group employers under existing Healthy New York coverage. We made adjustments as appropriate in order to project the experience claims forward and account for the expected market dynamics in 2014.

Summary Discussion: First the existing experience claims are normalized. An adjustment is made to bring the claims to the current mix of business by area, benefit plan, etc. We further adjust for the difference between the current average benefit level and the anchor Platinum plan. This provides a normalized claim base to project forward. Aetna then applied medical cost trend to project the claims from the experience period to the 2014 rating period. Our trend assumption is 10.3%, incorporating our expectations of utilization and unit cost. The resulting projected claim amount represents the expected claim PMPM for our anchor Platinum plan.

Detail Discussion: The numbered list below discusses in turn each line item in the attached pricing development exhibit (Table 1).

1. Paid Claims PMPM (#2): Experience for the period 10/01/11 through 09/30/12, paid through 12/31/12. This is the average PMPM incurred claims for the experience period. We exclude from this PMPM any adjustments for the impact of the current Regulation 146 risk adjustment pool and Stop-Loss Reimbursement pool. Reserves - Claims Incurred But Not Paid were estimated using standard lag methods. We used three months of runoff to reduce the reliance on reserve estimates. The reserves represent 1.2% of the experience period claims.
2. Benefit Normalization (#3): Normalizes the baseline experience to the ending mix of benefit levels using historical Aetna benefit index data.
 - a. Average AV pricing value for all inforce plans in effect during the experience period, based on member-months.
 - b. Difference between the ending mix of benefit levels in the experience period and the benefit level of the selected anchor Platinum plan.
 - c. EHB adjustment for the value of additional Essential Health Benefits (EHB) as a percentage of the selected Platinum plan
3. Tier ratio adjustment (#5): Adjusts the current tier ratio relationship to the NY Department of Financial Service (NY DFS or DFS) prescribed tier ratios.
4. Market Level Risk Adjustment (#6): Estimate of the impact of the federal risk adjustment program. The impact of risk adjustment in the 2014 NY small group marketplace was based on the simulation study that was conducted by Deloitte on behalf of DFS. Our own analysis of the block indicates stable morbidity and health status, consistent with the data provided to Deloitte, and we do not expect material changes in 2014. Based on these projections of the market in 2014, this adjustment is +21.8%.
5. Allowed Trend (#8): Annual trend on allowed costs incorporating our expectations of utilization and unit cost. We utilized Aetna Large Group community rated HMO experience for the period 10/01/11 through 09/30/12 with run-out through 12/31/12 in order to project claims for this filing. No adjustments were made for large claims. The historical claims are normalized for demographics, tier, benefit changes, case size, and area to the most recent month of the experience period, and a three month lagged annual experience period weighted average PMPM is calculated and projected forward with trend and seasonality. For this rate filing, we have used 10.3% as the projected change in medical cost.
6. Claim Trend Factor (#9): Midpoint of experience period of 10/1/11 to 9/30/12 is 4/1/12. Midpoint of 1Q2014 (1/1/14 to 3/31/14) is 2/15/14. This yields a projection period of 22.5 months.

7. Pediatric Dental (#11): Final guidance on the rating is expected from CCIIO but has not yet been received. For the purposes of this rate filing, we have added a flat amount to the claim portion of the index rate. We will re-evaluate and reserve the right to revise our pediatric dental rating once final rating guidance is received.
8. Platinum Index Final Claim Rate (#12): The final projected average PMPM incurred claims
9. Retention (#13) – Please see the separate section below for details on assumed retention.
10. Platinum Index Premium Rate (#14): The final Market Index Rate or projected average PMPM premium rate

Determination of Retention Portion of Market Index Rate

In setting the overall market index rate, we included provision for the following retention items:

1. Taxes and Fees of 5.6% comprised of:
 - a. Premium Taxes of 1.9 %
 - b. Patient Centered Outcomes Research Fund of \$2.00 per member per year, converted to 0.04%
 - c. Reinsurance Contribution of \$5.08 PMPM, converted to 1.1% based on effective date to account for differences in the contribution level year over year. Please see additional details below.
 - d. Health Insurer Fee of 2.6% based on effective date to account for differences in the fee level year over year. Please see additional details below.
 - e. As requested, Aetna did not include any Exchange Fees in this 2014 rate filing
2. Commissions of 2.4%, comprised of Variable Commissions
3. General Administrative Expenses of 6.9% comprised of Fixed expenses of \$32.83, converted to a percentage of premium
4. Risk Charge of 2%

Impact of PPACA Taxes and Fees

The Patient Protection and Affordable Care Act (PPACA) created several new fees assessed on insurers or health insurance. Two of these fees go into effect in 2014, described further below. Both fees are applicable to premium earned beginning in 2014, regardless of when the policy renews. Since the fees change in level from 2014 to 2015, the impact of the fees varies based on the effective date of the policies. For example, a policy renewed in July 2014 will have six months of premium in 2014 and six months in 2015.

1. Reinsurance Contribution (RC): This is a temporary fee, designed to fund the temporary reinsurance program that will cover the individual markets for the years 2014 through 2016. The fee is assessed on fully insured and self-insured group health plans. There will be a standard national assessment for the RC, as well as the option for states to assess an additional state-level assessment. The total amount to be collected under the national assessment in 2014 is \$12 billion, declining to \$8 billion in 2015 and \$5 billion in 2016. Aetna has calculated the impact for the 2014 RC fee based on the final regulation for policies issued in NY to be worth approximately 1.0% of premium.
2. Health Insurer Fee (HIF): This permanent industry fee will be assessed based on each insurer's share of the fully insured market, in order to collect a total of \$8.0 billion for 2014.

The total assessment will increase each year, to \$14.3 billion in 2018 and increasing at the rate of premium growth thereafter. Aetna has calculated the impact for the 2014 HIF fee based on current regulations to be approximately 2.7% of premium.

These two fees must be incorporated into premium rates to reflect the added costs. We will incorporate them on a “stepped” basis in order to reflect the actual portion of each policy’s premium that will be subject to the fees in each calendar year. The table below shows the impact of these fees on premiums by renewal quarter. The factors shown in the third and fourth columns are applied by multiplying the factor with the base premium.

Renewal / Effective Date	No. of Months of Premium in 2014	No. of Months of Premium in 2015	RC Factor	HIF Factor	Total Premium Impact
1Q14	12	0	1.011	1.026	3.7%
2Q14	9	3	1.010	1.027	3.7%
3Q14	6	6	1.009	1.027	3.6%
4Q14	3	9	1.008	1.028	3.6%

Based on the current distribution by renewal month, we expect the overall impact of these fees for this filing to be 3.6%.

- Exchange User Fee: The financing plan for the New York Exchange Marketplace has not been finalized. As prescribed in NY SG rate filing checklist, no fees were built into this rate development.

The final Market Index Rate was calculated as Projected Claims / (1 – Taxes and Fees – Commissions – General Administrative Expenses – Risk Charge) to be \$473.28. This rate represents the proposed base premium rate PMPM for our anchor Platinum plan provided in the Premium Rate Manual – Section B Page 4, and will be used as the basis for developing the plan premium rate PMPM for all other metallic-level plan designs discussed in this filing.

Rating Methodology

The requested rates for effective dates January 1, 2014 through December 31, 2014 are determined using the prescribed Tier ratio to determine the premium rate for each family tier.

Rate Formula

For each subscriber, calculate the Premium Rate as follows:

$$\text{Market Index Rate} * \text{Trend Factor} * \text{Area Factor} * \text{Plan Factor}$$

Use the NY DFS prescribed Tier ratio to convert the Premium Rate to Tiered Rates, and add them together to determine the total premium for the policy.

Market Index Rate

The Market Index Rate for this filing is \$473.28, developed as described above.

Trend Factors – effective date factor

These factors are developed to account for differences in costs for those enrolling after January 1st of the calendar year, including only:

- the effect of medical cost trend, and
- differences in the impacts of HIF and RC already described above.

The factors are:

Effective Date	Effective Date factor
1Q14	1.0000
2Q14	1.0223
3Q14	1.0451
4Q14	1.0686

The medical trend assumptions are based on our Large Group HMO experience. Actual historical net claims were reviewed for the period 10/01/11 through 09/30/12 with run-out through 12/31/12. No adjustments were made for large claims. The historical claims are normalized for demographics, tier, benefit changes, case size, and area to the most recent month of the experience period, and a three month lagged annual experience period weighted average PMPM is calculated and projected forward with trend and seasonality. For this rate filing, we have used 10.3% as the projected change in medical cost. We believe our trend assumption is a reasonable estimate based on more than 3 years of the experience of this block of business.

The following table shows the trend assumptions by major types of service as defined by HHS, separately by unit cost, utilization, and in total.

Type of Service	Unit Cost	Utilization	Total
Inpatient Hospital	4.4%	5.7%	10.3%
Outpatient Hospital	4.4%	5.7%	10.3%
Professional	4.4%	5.7%	10.3%
Other Medical	4.4%	5.7%	10.3%
Capitation	0.0%	0.0%	0.00%
Prescription Drug	4.4%	5.7%	10.3%
Total			10.3%

Area Factors

Rating areas are defined by NY DFS. Rating Area factors are based on industry and company experience, and represent differences in expected provider costs and utilization patterns by area. The area factors are provided in Table 2.

For 2014, these factors are consistent with our currently filed area factors, remapped by county for changes in the defined 2014 rating areas compared to our current rating area definitions. To validate the currently filed factors, experience was reviewed at the county level, normalized for

demographics and health status, and adjusted for credibility. This analysis called for no changes to our Area Factors in our judgment, short of the afore-mentioned remapping to align with the 2014 defined areas.

Plan Factors

The Plan Factors represent the expected value of the difference in benefits and networks between the anchor Platinum plan and each additional proposed benefit plan discussed in this filing. The factors were developed using a proprietary pricing model which relies on State- and product-specific benefit service category weights and rating factors for various levels of plan/member cost-sharing options for deductibles, coinsurance, out-of-pocket maximums and copays.

The product-specific service category weights were developed based on the experience of Aetna's Small Group block of business. The cost-sharing-specific rating factors were developed using experience associated with our Large Group block of business, which excludes the effects of selection. These Large Group based cost-sharing specific rating factors account for differences in a standard population's spending patterns due to differences in the richness and/or structure of benefits, or induced demand, without reflection of differences in health status.

Final plan factors reflect the value of the EHB and state mandated benefits, incorporating the impact of out-of-network benefits and additional benefits. The methodology also considers the value of any differences in network by plan, including but not limited to network discounts and steerage. For instance, the Healthy NY plan option is based upon a broad state-wide network while the NYCCP plan options are based upon a limited geographic network confined to the five boroughs of New York City; the impact of this difference is reflected in the pricing plan factors.

We offer all plans with and without religious exemption. Plans with "RE" at the end of the plan name denote the corresponding plans with religious exemptions applied. Religious exemption plans exclude contraceptives (oral, injectable and devices), contraceptive counseling and voluntary sterilization (tubal ligation and vasectomy). We have adjusted the plan factors of the RE plans accordingly as shown in Table 3.

The factors and HHS AV values for each plan are shown in Table 3 attached.

Certification

I, Theresa S. Bauer am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries. I hereby certify that to the best of my knowledge and judgment, this rate filing is in compliance with all applicable laws and regulations of the State of New York; the requirements under federal law and regulation; Actuarial Standard of Practice No. 8, "Regulatory Filings for Health Plan Entities" " as adopted by the Actuarial Standards Board, including ASOPs No. 5, 12, 23, 25 and 41. I also certify that the expected loss ratio incorporated into the rate tables meets the minimum requirements of the State of New York. I assert that the benefits are reasonable in relation to the premiums, and that the calculations are based on my best estimate of the future experience. I further attest that to the best of my knowledge, the rates are not excessive, inadequate, or unfairly discriminatory.

[Redacted Signature]

[Redacted Name]
Aetna Health Inc.

5/15/2013
Date

Aetna Health Inc.
New York Small Group
SERFF Tracking Number: AETN-128992632

Table 1
Market Index Rate Development

		Small Group
		HMO
1)	Member Months (Oct 11-Sep 12)	113,425
2)	Paid Claims PMPM (Oct 11-Sep 12)	\$286.21
3)	Normalize:	
a)	Weighted Average Benefit Factor	/ 0.9947
b)	Benefit Index for Platinum Plan	x 0.8791
c)	EHB Adjustment	x 1.0244
4)	Normalized PMPM Claims Subtotal	= \$259.14
5)	Tier Ratio Adjustment	x 1.0287
6)	Market Level Risk Adjustment	x 1.2177
7)	Comparative HCR Claims per Segment	= \$324.61
8)	Allowed Claim Trend - Rate	10.30%
	No. of Months	22.5
9)	Claim Trend Factor	x 1.2018
10)	Platinum Index Base Claim Rate	= \$390.11
11)	Pediatric Dental	+ \$2.91
12)	Platinum Index Final Claim Rate	= \$393.02
13)	1 - Retention	/ 83.04%
14)	Platinum Index Premium Rate	= \$473.28

Aetna Health Inc.

New York Small Group

Table 2

Rating Area Factors

Rating Region	Counties	Area Factor
Region 1	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	0.9044
Region 2	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	0.9044
Region 3	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster	1.0000
Region 4	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester	1.0000
Region 5	Livingston, Monroe, Ontario, Seneca, Wayne, Yates	0.9044
Region 6	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins	0.9044
Region 7	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	0.9044
Region 8	Nassau, Suffolk	1.0000

Aetna Health Inc.

New York Small Group

Table 3

AV and Plan factors

<u>PPID</u>	<u>Plan</u>	<u>Exchange</u> <u>ON/OFF</u>	<u>Metallic Tier</u>	<u>Actuarial</u> <u>Value</u>	<u>Plan</u> <u>Factors</u>
14018914	NY Gold Healthy NY	OFF	Gold	79.0%	1.166
6414869	NY Platinum NYC Community PlanSM \$20	OFF	Platinum	89.3%	1.000
6414870	NY Platinum NYC Community PlanSM \$30	OFF	Platinum	88.7%	0.964
14018911	NY Gold Healthy NY RE	OFF	Gold	79.0%	1.149
14018909	NY Platinum NYC Community PlanSM \$20 RE	OFF	Platinum	89.3%	0.985
14018910	NY Platinum NYC Community PlanSM \$30 RE	OFF	Platinum	88.7%	0.950



[REDACTED]
Small Group, RS12
Aetna Health, Inc.
151 Farmington Avenue
Hartford, CT 06156
Phone: 8 [REDACTED]
Email: [REDACTED]

May 15, 2013

[REDACTED]
New York State Insurance Department
25 Beaver Street - Health Bureau
New York, NY 10004-2319

Subject: Aetna Health, Inc. of NY
SERFF ID: AETN-128992632

Dear [REDACTED]

Enclosed for your Department's review and approval please find a rate filing that provides Comprehensive Medical Expense insurance coverage to small group employers of the State of NY.

The purpose of this filing is to provide details of the premium rate development and resulting proposed monthly premium rates for Small Group policies which will be offered off-Exchange in the State of NY by Aetna Health, Inc. of NY (Aetna) for effective dates of January 1, 2014 and later. This filing is being provided to comply with regulatory rate filing requirements and is not intended to be used for other purposes.

The health benefit plans proposed in this filing are new benefit plans and are in compliance with all state-specific benefit requirements and rating regulations, as well as those associated with Federal Health Care Reform H.R. 3590 – the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010. Additionally, these health benefit plans conform to each respective tier of coverage, defined as Bronze, Silver, Gold, and Platinum. All plans within a tier are expected to achieve an actuarial value consistent with the thresholds established for each tier – 60%, 70%, 80%, and 90%, respectively – approximated within the allowable range of deviation defined as 2 percentage points.

This rate filing is intended for new business issued through the State of NY off-Exchange marketplace effective January 1, 2014.

All products and associated proposed monthly premium rates contained within this rate filing will be available to existing business upon their request. Existing business that is not considered grandfathered under PPACA regulation will be converted to the plans and rates in this filing upon renewal.

Mr. Gary Teitel
May 15, 2013
Page 2 of 2

This submission includes the following:

- Actuarial Memorandum and Certification,
- NY SG Rate Manual, and
- NY required standard exhibits

We have tried to present this information in a manner that will facilitate your Department's review. If there are changes we can make to improve the process or you would like us to present the information differently in the future, please let us know.

Please feel free to contact me at the above listed telephone number and/or e-mail address if you have any additional questions.

Very truly yours,

A large black rectangular redaction box covering the signature area.A small black rectangular redaction box covering the name.

Aetna Small Group Actuarial

Encl: a/s

Actuarial Memorandum and Certification In Support of Unified Rate Review Template

General Information

Company Identifying Information:

- Company Legal Name: Aetna Health Inc. (a NY corp.)
- State: New York
- HIOS Issuer ID: 50138
- Market: Small Group
- Effective Date: 1/1/2014

Company Contact Information:

- Primary Contact Name: Brian Diiorio
- Primary Contact Telephone Number: 215-775-0314
- Primary Contact Email Address: DiiorioB@AETNA.com

Proposed Rate Increase(s)

No rate increase is proposed in this filing.

Experience Period Premium and Claims

Paid Through Date: The experience is paid through February 2013. The experience period shown is 1/1/2012 – 12/31/2012.

Premiums (net of MLR Rebate) in Experience Period: The premiums shown are date-of-service premiums from our actuarial experience dataset. For the Small Group New York Minimum Loss Ratio pool in 2012, there is a projected rebate of \$2,683,072. This is based on the 4/1/2013 reports as well as internal projections showing that the MLR is expected to exceed 80%. Therefore, these expected rebates were adjusted out of the premiums.

Allowed and Incurred Claims Incurred During the Experience Period:

- Incurred But Not Reported reserves are estimated using actuarial principles and assumptions that consider among other things, historical and projected claim submission patterns, historical and projected claim processing time, medical cost trends, utilization of health care services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors. For the experience period, we used two months of paid claim runoff to reduce the reliance on reserve estimates in the most recent incurred months. The IBNR reserves represent 1.2% of the experience period claims.
- Our medical cost analysis systems that provide estimates of completed allowed claims as well as utilization and unit cost metrics do not readily distinguish between Grandfathered and Non-Grandfathered blocks of business. Therefore, we used reports that include both portions of the existing experience block to estimate the relationship between incurred paid claims and incurred allowed claims. We also used this data to estimate the unit cost and utilization metrics and to allocate total incurred claims to the medical cost categories shown.

- The Allowed claims are completed using the relationship between paid and completed paid claims, with data quality edits to ensure that allowed amounts are not skewed by the factors. The method tends to be less reliable for recent time periods, similar to paid completion. These reports were paid through March 2013, and the data for calendar year 2012 is considered to be reliable with three months of paid and allowed claim runoff.

Benefit Categories

The benefit categories used generally align with the instructions (dated March 18, 2013). Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, while Outpatient Hospital includes outpatient surgical as well as emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses. Other includes home health care, mental health care, medical pharmacy expenses, as well as laboratory and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

Projection Factors

Changes in the Morbidity of the Population Insured: The projected change in the morbidity of the population is based on modeling described in further detail in the actuarial memorandum included in the rate filing dated May 15, 2013. It includes the estimated impact of the federal risk adjustment program. The impact of risk adjustment in the 2014 NY small group marketplace was based on the simulation study that was conducted by Deloitte on behalf of DFS. Our own analysis of the block indicates stable morbidity and health status, consistent with the data provided to Deloitte, and we do not expect material changes in 2014. Based on these projections of the market in 2014, this adjustment is +21.8%.

Trend Factors (cost/utilization): The trends utilized for the projections for New York were developed based on Large Group experience for HMO plans for the New York market. Actual historical net claims are reviewed at the market level. The data utilized in the trend analysis was based on the claim data incurred from October 1, 2011 through September 30, 2012 with run-out through 12/31/12. No adjustments were made for large claims. The historical claims are normalized for demographics, tier, benefit changes, case size, and area to the most recent month of the experience period, and a three month lagged annual experience period weighted average PMPM is calculated and projected forward with trend and seasonality. For this rate filing, we have used 10.3% as the projected change in medical cost.

Changes in Benefits / Demographics / Other Adjustments: The expected mix of business for 2014 was projected and used to determine a projected market average rate. The effect of the change in mix of business due to differences in benefits, demographics, and area is shown in the "Other" adjustment column.

Credibility Manual Rate Development

We relied fully upon our experience data and have therefore not provided manual rating assumptions.

Credibility of Experience

Aetna's standard for full credibility is 24,000 member months. The New York experience exceeds this threshold.

Paid to Allowed Ratio

We are projecting the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 89%:

<u>Tier</u>	<u>Projected Membership Distribution</u>	<u>Actuarial Value</u>
Gold	10.00%	80%
Platinum	90.00%	90%
Total	100.00%	89%

Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM:

Aetna is projecting a neutral impact of risk adjustment. We expect that we will have membership enrolled at approximately the market morbidity.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only):

Not applicable

Non-Benefit Expenses and Profit & Risk

Non-benefit expense and profit & risk loads are determined on a PMPM and percentage of premium basis. We calculate the expected equivalent percentage of premium to determine the required premium level. Premiums for all plans and products in this market reflect this target percentage for expenses and profit.

In setting the overall market index rate, we included provision for the following retention items:

1. Taxes and Fees of 5.6% comprised of:
 - a. Premium Taxes of 1.9 %
 - b. Patient Centered Outcomes Research Fund of \$2.00 per member per year, converted to 0.04%
 - c. Reinsurance Contribution of \$5.08 PMPM, converted to 1.1% based on effective date to account for differences in the contribution level year over year. Please see additional details below.
 - d. Health Insurer Fee of 2.6% based on effective date to account for differences in the fee level year over year. Please see additional details below.

- e. As requested, Aetna did not include any Exchange Fees in this 2014 rate filing
2. Commissions of 2.4%, comprised of Variable Commissions
3. General Administrative Expenses of 6.9% comprised of Fixed expenses of \$32.83, converted to a percentage of premium
4. Risk Charge of 2%

Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is 83.4%, not including the credibility adjustment.

Index Rate

The index rate for the experience and projected periods are set equal to the actual and projected allowed claims, respectively, less non-EHB benefits. The non-EHB benefit is an adult eye exam every 12 months.

This index rate reflects the projected mix of business by plans. The AV pricing values for each plan were set based on the actuarial value and cost-sharing design of the plan as well as the plan's provider network, delivery system characteristics, and utilization management practices. Rates do not differ for any characteristic other than those allowable under the regulations as described in as described in 45 CFR Part 156, §156.80(d)(2). Administrative cost variation was not considered in development of AV pricing values.

AV Metal Values

Information regarding AV Metal Value determination including certifications and calculator snapshots is provided in the memorandum included in the rate filing dated May 15, 2013.

AV Pricing Values

The fixed reference plan is 50138NY0090000. Benefit factors were developed taking into account the expected benefit category weights and plan cost sharing. No adjustments were made to benefit factors to differentiate based on morbidity differences or benefit selection.

Membership Projections

Projections were entered at the product level rather than the plan level. Please see the section above on Paid to Allowed Ratio for projections by metallic tier.

Terminated Products

The following products will be closed to new sales prior to 1/1/2014 and are included in the Terminated Products reporting column in Worksheet 2:

- 50138NY002
- 50138NY003
- 50138NY005

Due to the late guidance, we have listed the terminated products separately but all their experience is still combined into the first terminated product column.

Warning Alerts

Total Premium (TP) differs between Worksheets 1 and 2 by \$463, or less than 0.001%. This is due to rounding of premiums and the need to allocate member months and dollars evenly to the plans reported at the product level.

Total Allowed Claims (TAC) does not differ between Worksheets 1 and 2. However, the spreadsheet indicates a Warning because it incorrectly subtracts Risk Adjustment and Reinsurance from Worksheet 1 before comparing to Worksheet 2.

Historical Rate Increases are not populated for New Products based on the guidance in instructions dated March 18, 2013. They are also not populated for Terminated Products based on verbal guidance in American Academy of Actuaries call of April 18, 2013, as well as the impracticability of reporting meaningful historical rate increases for a combination of products.

Actuarial Certification

Actuarial certification is provided in the rate filing dated May 15, 2013 for the methodology used to calculate the AV Metal Value for each plan.

I hereby certify that the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) was determined appropriately based on the claims expected to be paid for non-EHB benefits and the expected cost sharing and administrative expenses thereupon.

I hereby certify that the index rate is developed in accordance with federal regulations and the index rate and allowable modifiers are used in the development of plan specific premium rates.

In preparing the Part I Unified Rate Review Template, I relied upon information provided by Katherine Musler, FSA MAAA. The information provided consisted of guidance regarding methodology and data definitions to ensure compliance with all guidance and instructions received to date.

The Part I Unified Rate Review Template does not demonstrate the process used by Aetna to develop the rates. Rather 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.

[Handwritten signature]

[Redacted signature block]

May 15, 2013

[Redacted name] FSA, MAAA

Aetna Health, Inc.
New York Small Group HMO Filing
SERFF ID: AETN-128992632
Exhibit B

New York Small Group HMO Portfolio | Summary of Benefits

Contents

NY GOLD HEALTHY NY2
NY PLATINUM NYC COMMUNITY PLANSM \$204
NY PLATINUM NYC COMMUNITY PLANSM \$306
NY GOLD HEALTHY NY RE8
NY PLATINUM NYC COMMUNITY PLANSM \$20 RE 10
NY PLATINUM NYC COMMUNITY PLANSM \$30 RE 12

Summary of Benefits Covered

NY GOLD HEALTHY NY

New York Small Group

Gold Plan

Summary of Features In-Network

Deductible	
Individual	\$600
Family	\$1,200
Coinsurance <i>(Member Responsibility)</i>	20%
	<i>\$0 once out-of-pocket max. is satisfied</i>
Out-of-Pocket Maximum	
Individual	\$4,000
Family	\$8,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
Primary Care Visit to Treat an Injury or Illness <i>(excludes Preventative and X-rays)</i>	\$25 per visit after deductible
Specialist Visit	\$40 per visit after deductible
All Inpatient Hospital Services <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	\$1,000/Admit after deductible
Emergency Room Services	\$150 per visit after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$25 per visit after deductible
Imaging (CT/PET Scans, MRIs)	\$40 per visit after deductible
Rehabilitative Speech Therapy	\$30 per visit after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$30 per visit after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	\$40 per visit after deductible
X-rays and Diagnostic Imaging	\$40 per visit after deductible
Skilled Nursing Facility	\$1,000/Admit after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100 per visit after deductible
Outpatient Surgery Physician/Surgical Services	\$100 per visit after deductible

Pharmacy In-Network

Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	\$10 copay
Preferred Brand Drugs	\$35 copay
Non-Preferred Brand Drugs	\$70 copay
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

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

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSAs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$34.08	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	96%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?
 Specialty Rx Coinsurance Maximum: _____

Set a Maximum Number of Days for Charging an IP Copay?
 # Days (1-10): _____

Begin Primary Care Cost-Sharing After a Set Number of Visits?
 # Visits (1-10): _____

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
 # Copays (1-10): _____

Output

Calculate

Status/Error Messages: Calculation Successful.
 Actuarial Value: 79.0%
 Metal Tier: Gold

This product, NY Gold Healthy NY, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79%.

Summary of Benefits Covered

NY PLATINUM NYC COMMUNITY PLANSM \$20

New York Small Group

Platinum Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	N/A	
Family	N/A	
Coinsurance (Member Responsibility)	N/A	
	<i>\$0 once out-of-pocket max. is satisfied</i>	
Out-of-Pocket Maximum		
Individual	\$1,000	
Family	\$2,000	
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	\$20 per visit	30% after deductible
Specialist Visit	\$35 per visit	30% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	\$500/Admit	30% after deductible
Emergency Room Services	\$100 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$35 per visit	30% after deductible
Imaging (CT/PET Scans, MRIs)	\$35 per visit	30% after deductible
Rehabilitative Speech Therapy	\$35 per visit	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$35 per visit	30% after deductible
Preventive Care/Screening/Immunization	0%	30% after deductible
Laboratory Outpatient and Professional Services	0%	30% after deductible
X-rays and Diagnostic Imaging	\$35 per visit	30% after deductible
Skilled Nursing Facility	\$500/Admit	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150 per visit	30% after deductible
Outpatient Surgery Physician/Surgical Services	0%	30% after deductible
Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	\$10 copay	
Preferred Brand Drugs	\$50 copay	
Non-Preferred Brand Drugs	50% up to \$750	
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?

Apply Inpatient Copay per Day?

Apply Skilled Nursing Facility Copay per Day?

Rate OOP Maximum for Medical and Drug Spending?

Indicate if Plan Meets CSR Standard?

Desired Metal Tier: Platin

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input checked="" type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	92%
		2nd Tier Utilization:	8%

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00	\$5,000.00	\$0.00	
Coinsurance (%; Insurer's Cost Share)	100.00%	50.00%	70.00%	50.00%	
OOP Maximum (\$)	\$1,000.00		\$5,250.00		
OOP Maximum if Separate (\$)	\$1,000.00	\$0.00			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00

Options for Additional Benefit Design Limits:

a Maximum on Specialty Rx Coinsurance Payments?
 Specialty Rx Coinsurance Maximum: \$750

Maximum Number of Days for Charging an IP Copay?
 # Days (1-10):

Primary Care Cost-Sharing After a Set Number of Visits?
 # Visits (1-10):

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
 # Copays (1-10):

Output

Calculate

Status/Error Messages: Calculation Successful.

Actuarial Value: 89.3%

Metal Tier: Platinum

This product, NY Platinum NYC Community PlansM \$20 satisfies the HHS guidelines for a Platinum plan with an Actuarial Value of 89.3%.

Summary of Benefits Covered

NY PLATINUM NYC COMMUNITY PLANSM \$30

New York Small Group

Platinum Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	N/A	
Family	N/A	
Coinsurance (Member Responsibility)	N/A	
<i>\$0 once out-of-pocket max. is satisfied</i>		
Out-of-Pocket Maximum		
Individual	\$1,000	
Family	\$2,000	
<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>		
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	\$30 per visit	30% after deductible
Specialist Visit	\$50 per visit	30% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	\$1,000/Admit	30% after deductible
Emergency Room Services	\$150 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$50 per visit	30% after deductible
Imaging (CT/PET Scans, MRIs)	\$50 per visit	30% after deductible
Rehabilitative Speech Therapy	\$50 per visit	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$50 per visit	30% after deductible
Preventive Care/Screening/Immunization	0%	30% after deductible
Laboratory Outpatient and Professional Services	0%	30% after deductible
X-rays and Diagnostic Imaging	\$50 per visit	30% after deductible
Skilled Nursing Facility	\$1,000/Admit	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150 per visit	30% after deductible
Outpatient Surgery Physician/Surgical Services	0%	30% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	\$10 copay	
Preferred Brand Drugs	\$50 copay	
Non-Preferred Brand Drugs	50% up to \$750	
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?

Apply Inpatient Copay per Day?

Apply Skilled Nursing Facility Copay per Day?

Rate OOP Maximum for Medical and Drug Spending?

Indicate if Plan Meets CSR Standard?

Desired Metal Tier: Platin

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input checked="" type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	92%
		2nd Tier Utilization:	8%

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00	\$5,000.00	\$0.00	
Coinsurance (%; Insurer's Cost Share)	100.00%	50.00%	70.00%	50.00%	
OOP Maximum (\$)	\$1,000.00		\$5,250.00		
OOP Maximum if Separate (\$)	\$1,000.00	\$0.00			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input type="checkbox"/>	<input type="checkbox"/>		\$150.00
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	92%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00

Options for Additional Benefit Design Limits:

a Maximum on Specialty Rx Coinsurance Payments?
Specialty Rx Coinsurance Maximum: \$750

Maximum Number of Days for Charging an IP Copay?
Days (1-10):

Primary Care Cost-Sharing After a Set Number of Visits?
Visits (1-10):

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
Copays (1-10):

Output

Calculate

Status/Error Messages: Calculation Successful.

Actuarial Value: 88.7%

Metal Tier: Platinum

This product, NY Platinum NYC Community PlansM \$30 satisfies the HHS guidelines for a Platinum plan with an Actuarial Value of 88.7%.

Summary of Benefits Covered

NY GOLD HEALTHY NY RE

New York Small Group

Gold Plan

Summary of Features In-Network

Deductible	
Individual	\$600
Family	\$1,200
Coinsurance <i>(Member Responsibility)</i>	20%
	<i>\$0 once out-of-pocket max. is satisfied</i>
Out-of-Pocket Maximum	
Individual	\$4,000
Family	\$8,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>
Primary Care Visit to Treat an Injury or Illness <i>(excludes Preventative and X-rays)</i>	\$25 per visit after deductible
Specialist Visit	\$40 per visit after deductible
All Inpatient Hospital Services <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	\$1,000/Admit after deductible
Emergency Room Services	\$150 per visit after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$25 per visit after deductible
Imaging (CT/PET Scans, MRIs)	\$40 per visit after deductible
Rehabilitative Speech Therapy	\$30 per visit after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$30 per visit after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	\$40 per visit after deductible
X-rays and Diagnostic Imaging	\$40 per visit after deductible
Skilled Nursing Facility	\$1,000/Admit after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100 per visit after deductible
Outpatient Surgery Physician/Surgical Services	\$100 per visit after deductible

Pharmacy In-Network

Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	\$10 copay
Preferred Brand Drugs	\$35 copay
Non-Preferred Brand Drugs	\$70 copay
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

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

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSAs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$34.08	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	96%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?
 Specialty Rx Coinsurance Maximum: _____

Set a Maximum Number of Days for Charging an IP Copay?
 # Days (1-10): _____

Begin Primary Care Cost-Sharing After a Set Number of Visits?
 # Visits (1-10): _____

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
 # Copays (1-10): _____

Output

Calculate

Status/Error Messages: Calculation Successful.
 Actuarial Value: 79.0%
 Metal Tier: Gold

This product, NY Gold Healthy NY RE, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79%.

Summary of Benefits Covered

NY PLATINUM NYC COMMUNITY PLANSM \$20 RE

New York Small Group

Platinum Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	N/A	
Family	N/A	
Coinsurance (Member Responsibility)	N/A	
	\$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	\$1,000	
Family	\$2,000	
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	\$20 per visit	30% after deductible
Specialist Visit	\$35 per visit	30% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	\$500/Admit	30% after deductible
Emergency Room Services	\$100 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$35 per visit	30% after deductible
Imaging (CT/PET Scans, MRIs)	\$35 per visit	30% after deductible
Rehabilitative Speech Therapy	\$35 per visit	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$35 per visit	30% after deductible
Preventive Care/Screening/Immunization	0%	30% after deductible
Laboratory Outpatient and Professional Services	0%	30% after deductible
X-rays and Diagnostic Imaging	\$35 per visit	30% after deductible
Skilled Nursing Facility	\$500/Admit	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150 per visit	30% after deductible
Outpatient Surgery Physician/Surgical Services	0%	30% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	\$10 copay	
Preferred Brand Drugs	\$50 copay	
Non-Preferred Brand Drugs	50% up to \$750	
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?

Apply Inpatient Copay per Day?

Apply Skilled Nursing Facility Copay per Day?

Rate OOP Maximum for Medical and Drug Spending?

Indicate if Plan Meets CSR Standard?

Desired Metal Tier: Platin

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input checked="" type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	92%
		2nd Tier Utilization:	8%

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00	\$5,000.00	\$0.00	
Coinsurance (% Insurer's Cost Share)	100.00%	50.00%	70.00%	50.00%	
OOP Maximum (\$)	\$1,000.00		\$5,250.00		
OOP Maximum if Separate (\$)	\$1,000.00	\$0.00			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00

Options for Additional Benefit Design Limits:

a Maximum on Specialty Rx Coinsurance Payments?
 Specialty Rx Coinsurance Maximum: \$750

Maximum Number of Days for Charging an IP Copay?
 # Days (1-10):

Primary Care Cost-Sharing After a Set Number of Visits?
 # Visits (1-10):

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
 # Copays (1-10):

Output

Calculate

Status/Error Messages: Calculation Successful.

Actuarial Value: 89.3%

Metal Tier: Platinum

This product, NY Platinum NYC Community PlansM \$20 RE satisfies the HHS guidelines for a Platinum plan with an Actuarial Value of 89.3%.

Summary of Benefits Covered

NY PLATINUM NYC COMMUNITY PLANSM \$30 RE

New York Small Group

Platinum Plan

Summary of Features		
	In-Network	Out-of-Network
Deductible		
Individual	N/A	
Family	N/A	
Coinsurance (Member Responsibility)	N/A	
	<i>\$0 once out-of-pocket max. is satisfied</i>	
Out-of-Pocket Maximum		
Individual	\$1,000	
Family	\$2,000	
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	\$30 per visit	30% after deductible
Specialist Visit	\$50 per visit	30% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	\$1,000/Admit	30% after deductible
Emergency Room Services	\$150 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$50 per visit	30% after deductible
Imaging (CT/PET Scans, MRIs)	\$50 per visit	30% after deductible
Rehabilitative Speech Therapy	\$50 per visit	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$50 per visit	30% after deductible
Preventive Care/Screening/Immunization	0%	30% after deductible
Laboratory Outpatient and Professional Services	0%	30% after deductible
X-rays and Diagnostic Imaging	\$50 per visit	30% after deductible
Skilled Nursing Facility	\$1,000/Admit	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150 per visit	30% after deductible
Outpatient Surgery Physician/Surgical Services	0%	30% after deductible
Pharmacy		
	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	\$10 copay	
Preferred Brand Drugs	\$50 copay	
Non-Preferred Brand Drugs	50% up to \$750	
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?

Apply Inpatient Copay per Day?

Apply Skilled Nursing Facility Copay per Day?

Rate OOP Maximum for Medical and Drug Spending?

Indicate if Plan Meets CSR Standard?

Desired Metal Tier: Platin

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input checked="" type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	92%
		2nd Tier Utilization:	8%

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00	\$5,000.00	\$0.00	
Coinsurance (% Insurer's Cost Share)	100.00%	50.00%	70.00%	50.00%	
OOP Maximum (\$)	\$1,000.00		\$5,250.00		
OOP Maximum if Separate (\$)	\$1,000.00	\$0.00			

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input type="checkbox"/>	<input type="checkbox"/>		\$150.00
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	92%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	50%	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00

Options for Additional Benefit Design Limits:

a Maximum on Specialty Rx Coinsurance Payments?
Specialty Rx Coinsurance Maximum: \$750

Maximum Number of Days for Charging an IP Copay?
Days (1-10):

Primary Care Cost-Sharing After a Set Number of Visits?
Visits (1-10):

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
Copays (1-10):

Output

Calculate

Status/Error Messages: Calculation Successful.

Actuarial Value: 88.7%

Metal Tier: Platinum

This product, NY Platinum NYC Community PlansM \$30 RE satisfies the HHS guidelines for a Platinum plan with an Actuarial Value of 88.7%.

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:	<u>Aetna Health Inc. (NY)</u> <small>Company submitting the rate adjustment request</small>	<u>HMO - 44</u> <small>Company Type</small>	<u>For Profit</u> <small>Org. Type</small>	<u>95234</u> <small>Company NAIC Code</small>
	<u>151 Farmington Ave.</u> <u>Hartford, CT 06156</u> <small>Company mailing address</small>			
B. Contact Person:	██████████ <u>Actuarial Analyst</u> <small>Rate filing contact person name, title</small>	██████████ <small>Contact phone number</small>	████████████████████ <small>Contact Email address</small>	
C. Actuarial Contact (If different from above):	██████████ <u>Actuary</u> <small>Actuary name, title</small>	██████████ <small>Actuary phone number</small>	████████████████████ <small>Actuary Email address</small>	
D. New Rate Information (See Note #1):	<u>January 1, 2014 to December 31, 2014</u> <small>New rate applicability period</small>	<u>01/01/2014</u> <small>New rate effective date</small>	<u>AETN-128992632</u> <small>SERFF Tracking Number</small>	
E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):	<u>Small Group</u>			
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. The plans covered in this filing are new plans.			
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 prefilling.	N/A			

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 7A: Calculation of Standardized Premium

Aetna Health Inc

Premium PMPM

New York Small Group

Cohort	DOS Month														
	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
Jan	553.83	560.10	565.46	536.67	524.82	516.72	524.43	507.39	524.79	517.33	520.89	520.21	460.68	515.58	513.15
Feb	399.40	402.75	402.91	403.37	404.24	397.30	403.20	390.99	403.97	399.58	399.11	396.37	280.76	385.65	371.03
Mar	488.68	493.88	492.37	480.91	480.13	426.49	433.97	422.55	406.05	400.29	401.26	401.59	324.94	397.49	388.46
Apr	534.67	536.64	540.74	533.75	535.13	527.12	487.28	481.38	496.63	496.23	490.94	479.74	427.45	463.76	459.28
May	417.80	412.97	420.55	416.33	417.63	405.72	418.23	371.16	383.38	381.23	372.64	377.19	299.87	368.56	366.33
Jun	428.75	434.16	434.66	427.11	426.06	414.49	424.90	403.20	384.02	371.07	373.34	375.37	292.72	369.80	363.43
Jul	582.88	597.40	601.02	604.51	606.83	610.83	629.58	625.70	631.85	550.74	548.35	532.69	474.67	516.93	516.49
Aug	448.46	459.20	470.95	461.52	465.17	461.38	464.99	452.83	466.65	457.64	389.91	378.67	294.86	376.55	367.82
Sep	459.58	484.92	491.96	490.20	493.41	482.30	495.61	472.83	482.24	470.34	471.42	440.60	359.46	431.63	426.37
Oct	402.86	410.67	417.23	412.18	410.79	396.70	405.43	391.93	409.01	403.41	406.23	407.44	311.37	382.76	374.51
Nov	539.93	443.63	448.74	437.02	439.30	430.06	437.80	426.43	438.62	432.96	434.83	435.70	360.29	392.86	387.77
Dec	487.51	491.96	422.24	408.57	379.59	370.56	379.46	369.08	382.76	375.03	374.57	377.20	282.43	375.21	346.89
Tot	475.20	476.96	475.09	467.17	461.64	446.81	454.22	436.35	440.60	432.54	427.22	423.67	343.08	411.67	400.46

Member Months

Cohort	DOS Month														
	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
Jan	488	478	464	521	502	500	489	482	476	467	447	447	440	452	451
Feb	369	353	354	343	511	507	482	472	469	465	447	447	451	452	449
Mar	571	548	534	526	530	722	710	708	666	658	656	642	629	631	630
Apr	347	344	336	333	330	323	497	485	482	465	467	440	455	456	455
May	400	410	394	383	381	379	372	542	541	527	514	496	498	493	485
Jun	442	428	427	424	430	428	425	421	627	600	583	573	565	565	559
Jul	282	264	264	253	247	241	247	248	247	332	339	351	341	342	337
Aug	311	301	297	294	287	269	269	269	266	261	482	462	451	442	441
Sep	437	378	372	359	352	351	345	357	362	361	358	504	482	462	460
Oct	337	318	322	312	305	307	306	309	305	308	291	294	524	514	503
Nov	173	310	310	295	286	282	281	279	277	276	270	266	253	449	431
Dec	220	212	386	385	372	361	360	350	337	336	331	326	320	315	703
BoB	4,377	4,344	4,460	4,428	4,533	4,670	4,783	4,922	5,055	5,056	5,185	5,248	5,409	5,573	5,904

Cumulative Rate Increase

Cohort	DOS Month														
	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
Jan	1.475	1.475	1.475	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228
Feb	1.475	1.475	1.475	1.475	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228
Mar	1.475	1.475	1.475	1.475	1.475	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228	1.228
Apr	1.393	1.393	1.393	1.393	1.393	1.393	1.192	1.192	1.192	1.192	1.192	1.192	1.192	1.192	1.192
May	1.393	1.393	1.393	1.393	1.393	1.393	1.393	1.192	1.192	1.192	1.192	1.192	1.192	1.192	1.192
Jun	1.393	1.393	1.393	1.393	1.393	1.393	1.393	1.393	1.192	1.192	1.192	1.192	1.192	1.192	1.192
Jul	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.135	1.135	1.135	1.135	1.135	1.135
Aug	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.135	1.135	1.135	1.135	1.135
Sep	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.135	1.135	1.135	1.135
Oct	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.135	1.135	1.135
Nov	1.357	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.135	1.135
Dec	1.357	1.357	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.277	1.135

Historical Rate Increases		
QTR	QRTL	to 4Q13
4Q07	1.050	1.545
1Q08	1.053	1.467
2Q08	1.050	1.397
3Q08	1.030	1.357
4Q08	1.000	1.357
1Q09	0.920	1.475
2Q09	1.058	1.393
3Q09	1.091	1.277
4Q09	1.000	1.277
1Q10	1.040	1.228
2Q10	1.030	1.192
3Q10	1.050	1.135
4Q10	1.000	1.135
1Q11	1.000	1.135
2Q11	1.000	1.135
3Q11	1.030	1.102
4Q11	1.000	1.102
1Q12	0.960	1.148
2Q12	1.020	1.126
3Q12	1.020	1.104
4Q12	1.000	1.104
1Q13	1.016	1.086
2Q13	1.028	1.057
3Q13	1.028	1.028
4Q13	1.028	1.000
1Q14	1.000	
2Q14	1.022	
3Q14	1.022	
4Q14	1.022	

	Billed Premium*	Std Premium**	Std/Billed
10/2009-09/2010	25,691,562	33,071,474	1.287
10/2010-09/2011	29,576,034	34,035,242	1.151
10/2011-09/2012	41,827,201	47,020,789	1.124

* - Sumproduct of Premium PMPM and Member Months
 ** - Sumproduct of Premium PMPM, Member Months, and Cumulative Rate Increase

Exhibit 7A:

Premium PMPM

Cohort	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Jan	404.58	397.94	405.58	404.33	397.87	399.50	376.31	356.71	360.59	361.75	359.63	368.67	344.30	344.52	344.81	345.67	346.49	347.38	347.53	346.87	347.19
Feb	383.45	359.04	365.91	366.26	363.49	370.57	366.68	365.95	367.14	369.35	365.53	377.25	361.90	349.42	350.95	351.26	351.70	351.60	351.82	351.61	352.10
Mar	398.94	386.28	372.92	362.59	364.28	369.09	366.15	363.17	364.63	367.18	364.27	375.00	364.25	363.75	350.22	349.55	350.31	349.97	350.00	350.01	350.61
Apr	460.52	458.10	465.96	396.45	394.98	394.77	395.56	393.05	388.67	392.63	386.51	393.12	385.02	388.88	393.31	369.31	372.41	372.22	369.34	369.68	369.83
May	365.50	357.06	366.67	370.91	363.16	368.69	365.93	365.92	361.59	364.70	359.66	373.26	361.18	356.55	356.90	357.01	351.35	351.56	351.99	351.89	352.77
Jun	371.04	362.39	369.72	371.18	370.97	358.66	354.53	356.76	356.87	359.73	357.21	362.53	352.90	351.98	350.42	350.18	352.25	352.37	353.30	352.36	351.77
Jul	512.38	514.52	516.77	513.13	512.11	562.60	441.98	438.14	497.11	493.43	492.96	497.56	491.62	489.58	492.21	488.36	491.34	487.27	408.26	405.73	407.72
Aug	372.87	364.50	373.03	373.34	373.09	379.98	409.22	403.92	404.41	403.15	392.71	401.15	384.90	384.93	385.11	386.30	389.54	391.32	391.19	350.52	351.28
Sep	436.56	428.65	437.41	435.69	436.78	440.96	434.92	431.75	401.15	401.75	401.25	405.42	398.15	402.51	402.75	404.06	404.92	401.65	403.49	403.19	351.28
Oct	381.96	378.97	382.19	381.68	384.88	389.40	386.35	385.78	386.31	386.16	384.04	392.22	382.58	384.41	385.34	381.08	383.85	383.05	385.74	387.48	388.22
Nov	383.88	377.74	375.20	371.16	372.46	376.52	361.12	361.86	364.97	365.24	362.19	368.11	358.45	358.37	360.39	360.29	358.78	358.56	359.44	358.63	361.53
Dec	357.20	350.38	352.43	353.75	353.12	358.56	355.46	354.36	355.14	356.34	353.42	372.03	357.13	358.29	361.16	361.27	366.73	367.52	366.00	367.37	367.43
Tot	398.11	388.71	391.96	386.52	384.96	386.90	379.82	377.68	380.67	382.12	377.97	386.16	372.25	370.05	368.21	366.40	366.89	365.80	364.96	362.71	360.12

Member Months

Member Months	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Jan	676	667	650	635	632	630	602	583	566	556	555	554	1,087	1,090	1,071	1,061	1,038	1,012	1,021	998	983
Feb	443	697	686	683	666	644	644	613	600	597	618	604	598	1,203	1,185	1,176	1,123	1,110	1,107	1,102	1,086
Mar	597	587	877	873	846	816	799	824	816	799	799	770	763	751	1,519	1,519	1,505	1,505	1,478	1,465	1,470
Apr	437	420	410	759	760	747	733	722	734	680	668	657	654	637	638	1,161	1,133	1,135	1,132	1,135	1,126
May	486	484	457	443	630	621	589	582	572	565	567	549	530	524	519	511	1,183	1,173	1,162	1,149	1,134
Jun	545	526	495	480	474	941	924	882	869	861	839	844	833	832	834	832	798	1,457	1,435	1,434	1,431
Jul	348	343	348	341	342	277	439	451	458	449	440	431	427	427	415	416	413	412	925	927	918
Aug	426	418	412	410	406	402	309	419	414	410	402	407	403	389	387	386	381	369	371	972	973
Sep	462	447	448	455	450	448	436	434	649	645	637	631	621	601	601	586	585	582	582	574	1,338
Oct	505	490	494	481	468	467	467	459	458	634	621	618	612	600	548	533	534	528	530	518	510
Nov	418	411	399	388	374	358	349	338	319	319	592	572	571	566	534	533	525	518	516	514	486
Dec	677	669	672	661	656	651	632	623	616	603	605	961	945	928	915	921	869	872	870	868	876
BoB	6,020	6,159	6,348	6,609	6,704	7,002	6,923	6,930	7,071	7,118	7,343	7,598	8,044	8,548	9,166	9,635	10,087	10,673	11,129	11,656	12,331

Cumulative Rate Cumulative Rate Increase

Cumulative Rate Cumulative Rate Increase	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Jan	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.148	1.148	1.148	1.148	1.148	1.148	1.148	1.148	1.148
Feb	1.228	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.148	1.148	1.148	1.148	1.148	1.148	1.148	1.148
Mar	1.228	1.228	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.148	1.148	1.148	1.148	1.148	1.148	1.148
Apr	1.192	1.192	1.192	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.126	1.126	1.126	1.126	1.126	1.126
May	1.192	1.192	1.192	1.192	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.126	1.126	1.126	1.126	1.126
Jun	1.192	1.192	1.192	1.192	1.192	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.126	1.126	1.126	1.126
Jul	1.135	1.135	1.135	1.135	1.135	1.135	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.104	1.104	1.104
Aug	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.104	1.104
Sep	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.104
Oct	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102
Nov	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102
Dec	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.135	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102	1.102

**Aetna Health Inc.
New York Small Group**

Month/Year Incurred	Membership	Normalized Medical Claims PMPM		Annualized Medical Trend
		1-Month	12-Month Rolling	12-Month Rolling
Jan-10	2,948	231.67		
Feb-10	3,011	198.79		
Mar-10	3,154	273.05		
Apr-10	3,274	237.77		
May-10	3,419	253.62		
Jun-10	3,550	311.65		
Jul-10	3,562	279.98		
Aug-10	3,728	297.39		
Sep-10	3,790	272.16		
Oct-10	3,928	274.87		
Nov-10	4,101	218.18		
Dec-10	4,441	238.53	257.91	
Jan-11	4,561	207.51	254.48	
Feb-11	4,702	196.67	252.23	
Mar-11	4,857	242.14	249.83	
Apr-11	5,081	214.19	246.99	
May-11	5,175	243.58	246.20	
Jun-11	5,479	259.18	243.19	
Jul-11	5,405	223.48	238.89	
Aug-11	5,418	256.90	236.77	
Sep-11	5,564	223.52	233.23	
Oct-11	5,608	274.12	234.32	
Nov-11	5,821	227.19	234.72	
Dec-11	6,051	228.37	233.85	-9.3%
Jan-12	6,503	254.93	237.76	-6.6%
Feb-12	7,034	198.67	236.56	-6.2%
Mar-12	7,662	289.03	241.86	-3.2%
Apr-12	8,163	225.46	241.95	-2.0%
May-12	8,615	278.30	245.89	-0.1%
Jun-12	9,199	269.71	247.69	1.9%
Jul-12	9,653	259.28	250.54	4.9%
Aug-12	10,183	308.29	256.69	8.4%
Sep-12	10,862	221.89	254.66	9.2%
Oct-12	11,236	267.21	254.97	8.8%
Nov-12	11,601	230.49	253.83	8.1%
Dec-12	12,110	240.29	253.74	8.5%

Average Last 6 with 1 month lag: **6.9%**

Trend Pick: **10.3%**

Using actual membership through Dec-12.
Claim projections are based on actual claim experience through Nov-12,
with no adjustment for large claims.

**Aetna Health Inc.
New York Small Group**

Month/Year Incurred	Membership	Normalized Medical Claims PMPM		Annualized Medical Trend
		1-Month	12-Month Rolling	12-Month Rolling
Jan-10	50,220	270.07		
Feb-10	48,147	286.53		
Mar-10	45,500	314.00		
Apr-10	43,326	306.27		
May-10	40,907	295.99		
Jun-10	37,749	334.99		
Jul-10	36,041	301.78		
Aug-10	34,582	308.63		
Sep-10	32,452	283.45		
Oct-10	31,492	316.03		
Nov-10	30,447	307.80		
Dec-10	29,107	279.19	299.73	
Jan-11	28,552	326.64	304.88	
Feb-11	28,343	290.84	306.04	
Mar-11	27,961	322.29	306.27	
Apr-11	27,784	314.16	306.84	
May-11	27,640	342.57	310.69	
Jun-11	27,279	319.57	308.82	
Jul-11	27,115	303.60	309.14	
Aug-11	26,987	339.15	311.54	
Sep-11	27,175	312.58	314.30	
Oct-11	27,153	337.47	316.01	
Nov-11	27,254	369.45	321.15	
Dec-11	27,815	334.64	325.97	8.8%
Jan-12	28,840	365.16	329.32	8.0%
Feb-12	29,157	402.79	339.06	10.8%
Mar-12	29,269	347.68	341.22	11.4%
Apr-12	29,543	346.76	343.95	12.1%
May-12	29,584	366.95	346.08	11.4%
Jun-12	29,756	340.31	347.71	12.6%
Jul-12	29,842	367.84	352.95	14.2%
Aug-12	30,042	357.75	354.45	13.8%
Sep-12	30,333	328.17	355.43	13.1%
Oct-12	30,746	344.87	355.89	12.6%
Nov-12	31,036	346.68	354.05	10.2%
Dec-12	31,719	381.26	357.95	9.8%

Average Last 6 with 3 month lag: 12.9%

Trend Pick: 11.8%

Using actual membership through Dec-12.
Claim projections are based on actual claim experience through Sep-12,
with no adjustment for large claims.

**Aetna Health Inc.
New York Small Group**

Exhibit 7C: Large Group Trend HMO

	Large Group Trend Data through December 2012		AVG 12	
	Membership	PMPM	PMPM	Rolling 12
200911	41,676	366.71		
200912	41,569	371.06		
201001	36,206	406.50		
201002	36,175	406.90		
201003	35,781	523.93		
201004	35,674	459.60	387.26	
201005	35,559	472.16	390.56	
201006	35,390	498.00	392.19	
201007	35,526	468.77	392.98	
201008	35,031	443.64	394.27	
201009	34,591	467.40	400.95	
201010	34,535	477.69	404.39	
201011	34,257	437.11	409.54	
201012	34,259	462.95	416.13	
201101	28,523	513.72	424.60	
201102	28,473	493.76	430.82	
201103	28,430	586.34	434.44	
201104	28,326	537.68	440.70	13.8%
201105	28,198	532.63	444.82	13.9%
201106	28,072	543.90	447.43	14.1%
201107	27,956	521.78	450.65	14.7%
201108	27,906	525.91	457.31	16.0%
201109	27,923	488.34	458.84	14.4%
201110	27,769	519.33	461.72	14.2%
201111	27,666	504.65	467.60	14.2%
201112	27,513	521.28	473.04	13.7%
201201	24,847	598.74	478.82	12.8%
201202	24,832	563.62	483.43	12.2%
201203	24,873	602.73	482.95	11.2%
201204	24,779	533.96	481.72	9.3%
201205	24,719	611.54	486.69	9.4%
201206	24,592	609.45	490.30	9.6%
201207	24,389	600.84	495.52	10.0%
201208	24,350	589.55	499.85	9.3%
201209	24,275	592.85	508.04	10.7%
201210	24,233	598.63	513.94	11.3%

Historical Average Trend 10.3%

**Aetna Health Inc.
New York Small Group**

Exhibit 7D: Unit Cost Trend

Line Of Business	Product	Reimbursement Type	DOS	FI Only		
CP	HMO/HNO	ALL	Mar-13	0.00%		
	Reimb. Type		2012	2013	2014	Average
	Facility		Latest Estimate	Latest Estimate	Latest Estimate	Estimate
New York	Total		6.77%	5.66%	6.54%	6.54%

	Reimb. Type		2012	2013	2014	Average
	Physician		Latest Estimate	Latest Estimate	Latest Estimate	Estimate
New York	Total		0.71%	1.38%	1.48%	1.48%

	Reimb. Type		2012	2013	2014	Average
	Total		Latest Estimate	Latest Estimate	Latest Estimate	Estimate
New York	Total		4.06%	3.80%	4.39%	4.39%

Weights

Facility:	59%
Physician:	41%

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Aetna Health Inc. (NY)
 NAIC Code: 95234
 SERFF Number: AETN-128992632
 Market Segment: SG

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

Line #	General							
1	Product*		HMO	HMO	HMO	HMO	HMO	HMO
2	Product ID*		50138NY009	50138NY009	50138NY011	50138NY009	50138NY009	50138NY011
3	Metal Level (or catastrophic)*		Platinum	Platinum	Gold	Platinum	Platinum	Gold
4	AV Metal Value (HHS Calculator)*		0.8931	0.8874	0.7899	0.8931	0.8874	0.7899
5	AV Pricing Value (total, risk pool experience based)*		1.0000	0.9643	1.1660	0.9852	0.9500	1.1488
6	Plan Type*		HMO	HMO	HNY	HMO	HMO	HNY
7	Plan Name*		NY Platinum NYC Community PlanSM \$20	NY Platinum NYC Community PlanSM \$30	NY Gold Healthy NY	NY Platinum NYC Community PlanSM \$20 RE	NY Platinum NYC Community PlanSM \$30 RE	NY Gold Healthy NY RE
8	Plan ID*		50138NY0090000	50138NY0090000	50138NY0110000	50138NY0090000	50138NY0090000	50138NY0110000
9	Exchange Plan?*		No	No	No	No	No	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	32,463,394						
10B	Member-Months for Latest Experience Period	113,425						
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	286.21						
11	Average Pricing Actuarial Value reflected in experience period	0.995						
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	287.73						

Market Wide Adjustments to the AV Adjusted Experience Period Index Rate

13	Impact of adjusting experience period data to EHB benefit level	1.0244						
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 **	1.218						
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)	1.000						
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)	1.202						
24	Other 1 (Adjustment to Platinum Plan level)	0.879						
25	Other 2 (Tier ratio adjustment)	1.029						
26	Other 3 (pediatric dental)	1.007						
27	Impact of Market Wide Adjustments (product L13 through L26)	1.366						

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	1.000	0.893	0.887	0.790	0.893	0.887	0.790
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.008	0.978	1.196	0.993	0.964	1.178
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.111	1.000	1.000	1.111
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.181	1.181	1.181	1.181	1.181	1.181	1.181
35	Profit/Contribution to surplus margins	1.020	1.020	1.020	1.020	1.020	1.020	1.020
36	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Other 1 (adjust Platinum metal level 0.9 to Pricing Anchor 1.0)	1.000	1.111	1.111	1.111	1.111	1.111	1.111
40	Other 2 (specify)	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	Impact of Plan Level Adjustments (product L28 through L40)	1.204	1.204	1.161	1.404	1.186	1.144	1.383

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)	473.28	473.28	456.37	551.85	466.28	449.63	543.70
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**Aetna Life Insurance Company
New York Small Group
Health Maintenance Organization**

Summary

Aetna is filing rates for Small Group plans in New York. These rates are for new plans that are compliant with new Affordable Care Act (ACA) provisions such as taxes and fees and increased benefit requirements. These rates also include medical trend increases.

Who is affected?

The new rates will apply to policies that start from January 2014 through December 2014. Approximately 10,878 members currently are enrolled in plans that will no longer be available due to ACA provisions. These members will have the option to enroll in the new plans included in this filing.

What are the major factors driving the rate level?

The impact of new ACA-related requirements are included in this rate filing:

- Taxes and Fees
- Increased Benefit Requirements – Essential Health Benefits, Minimum Actuarial Value, etc.

In addition to these new requirements, underlying medical costs are expected to increase in New York in 2014. These costs include hospital care, outpatient care and doctor fees; reimbursement for prescription drugs; and lab and X-ray fees.

How will premiums change?

The change in premiums that Small Groups pay will vary based on what they currently pay for their health coverage. Premiums also will differ based on the group's eligibility for government tax credits that could help to reduce the net cost of the new requirements.

How does this request align to Minimum Loss Ratio Requirements (MLR)?

These rates are expected to produce an MLR equal to or above the 80% requirement for Small Group business. Under the ACA, at least 80% of the premiums collected by health plans are expected to pay for medical care and activities that improve health care quality for members. If the actual MLR turns out to be less than 80%, rebates will be issued to customers in accordance with the law.

It should be noted that Aetna makes significant investments that benefit our members that the government does not allow us to use in this calculation. These investments include customer service, and health quality activities like disease management programs, as well as the development of new information technologies.

What is Aetna doing to keep premiums affordable?

Aetna is taking a number of steps to mitigate "rate shock" and address the underlying cost of health care, such as:

- Developing new agreements, arrangements or partnerships with health care providers that compensate them for the quality of care they provide, and not the quantity of services.
- Creating medical management programs that address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.

Aetna is also dedicated to increasing transparency within the health care system and helping members best utilize the plans that they have. Members can access Aetna Navigator, a secure member website, which allows them to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. Additionally, Aetna's Plan for Your Health website aims to educate all consumers, not just Aetna members, on how to take advantage of their health care benefits.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	X	Y								
1	Data Collection Template																															
2																																
3	Company Legal Name:		Aetna Health Inc. (a NY corp.)												State:		NY															
4	HIOS Issuer ID:		50138												Market:		Small Group															
5	Effective Date of Rate Change(s):		01/01/2014																													
6																																
7																																
8	Market Level Calculations (Same for all Plans)																															
9																																
10																																
11	Section I: Experience period data																															
12	Experience Period:		01/01/2012						to		12/31/2012																					
13			<u>Experience Period</u>																													
14			<u>Aggregate Amount</u>						<u>PMPM</u>		<u>% of Prem</u>																					
15	Premiums (net of MLR Rebate) in Experience Period:		44,786,867						\$343.11		100.00%																					
16	Incurred Claims in Experience Period		36,478,081						279.46		81.45%																					
17	Allowed Claims:		\$40,438,219						309.80		90.29%																					
18	Index Rate of Experience Period		\$309.00																													
19	Experience Period Member Months		130,531																													
20	Section II: Allowed Claims, PMPM basis																															
21			<u>Experience Period</u>						<u>Projection Period:</u>		01/01/2014						to		12/31/2014						<u>Mid-point to Mid-point, Experience to Projection:</u>		24 months					
22			<u>on Actual Experience Allowed</u>						<u>Adj't. from Experience to</u>		<u>Annualized Trend</u>						<u>Projections, before credibility Adjustment</u>						<u>Credibility Manual</u>									
23	<u>Benefit Category</u>		<u>Utilization Description</u>		<u>Utilization per 1,000</u>		<u>Average Cost/Service</u>		<u>PMPM</u>		<u>Pop'l risk Morbidity</u>		<u>Other</u>		<u>Cost</u>		<u>Util</u>		<u>Utilization per 1,000</u>		<u>Average Cost/Service</u>		<u>PMPM</u>		<u>Utilization per 1,000</u>		<u>Average Cost/Service</u>		<u>PMPM</u>			
24	Inpatient Hospital		Days		266.95		3,432.61		\$76.36		1.218		0.963		1.044		1.057		362.88		\$3,601.96		\$108.92		0.00		0.00		\$0.00			
25	Outpatient Hospital		Visits		314.11		1,242.98		32.54		1.218		0.963		1.044		1.057		426.99		1,304.30		46.41		0.00		0.00		0.00			
26	Professional		Visits		4,548.43		222.12		84.19		1.218		0.963		1.044		1.057		6,182.95		233.08		120.09		0.00		0.00		0.00			
27	Other Medical		Visits		3,559.03		236.16		70.04		1.218		0.963		1.044		1.057		4,838.00		247.81		99.91		0.00		0.00		0.00			
28	Capitation		Benefit Period		0.00		0.00		0.00		1.218		0.963		1.044		1.057		0.00		0.00		0.00		0.00		0.00		0.00			
29	Prescription Drug		Prescriptions		6,304.38		88.83		46.67		1.218		0.963		1.044		1.057		8,569.92		93.21		66.57		0.00		0.00		0.00			
30	Total								\$309.80																				\$0.00			
31																																
32	Section III: Projected Experience:																															
33																											After Credibility		Projected Period Totals			
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49	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.																															
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[REDACTED]
Product & Regulatory Approvals
Law and Regulatory Affairs
55 Lane Road
Fairfield, N.J. 07004
Phone Number: [REDACTED]
Fax Number: [REDACTED]
[REDACTED]

May 15, 2013

[REDACTED]
Health Bureau
New York State Department of Financial Services
One Commerce Plaza
Albany, New York 12257

Subject: **Aetna Health Inc. NAIC No. 95234**
Health Maintenance Organization
Small Group Off-Exchange Accident & Health Insurance
Forms: OffHIXHNYGR-96816, et al

[REDACTED]
The forms listed on the Attachment are being submitted for the Department's review and approval on a general use basis. The forms are in final format rather than being drafts or proofs.

These forms are intended for use with the Off-Exchange plans that will become available for small employers effective January 1, 2014. This submission will be used with the Healthy New York program and with Aetna's New York City Community Plan, which was approved by the Department on October 12, 2007 (File No 2007050105). The Schedule of Benefits attached to the Certificate form for Healthy New York supports the Gold metallic plan, and the Schedule of Benefits attached to the Certificate form for The New York City Community Plan supports the Platinum metallic plan.

The products being offered in these small group Off-Exchange plans are HMOs.

With respect to the Healthy New York program, In response to the Federal Affordable Care Act (ACA) final rules concerning the "Summary of Benefits and Coverage (SBC)" document which were published on February 14, 2012 and the "FAQS About Affordable Care Implementation (Part VIII)" which were jointly issued by the Departments of Labor, Health and Human Services, and Treasury on March 19, 2012, Aetna is making changes to its group contracts to include provisions which describe the Contract Holder's responsibilities with regards to the SBC Summary of Benefits and Coverages (SBC) and Notices of Material Modifications.

Aetna is adding this language for the following two reasons:

1. As stated in the preamble to the final rules, "*the Departments expect plans and issuers to make contractual arrangements for sending SBCs*" (77 FR 8671, FN 10).
2. Under question number 5 of the FAQs, where a plan and issuer have entered into binding contractual arrangement regarding the distribution of the SBC by a party, either or both the plan and issuer will not be subject to any enforcement action provided, among other things, that "*[t]he plan or issuer monitors performance under the contract*".

A detailed Explanation of Variability has been included.

We are also enclosing an Amendment to the Healthy New York contract that would permit Aetna to change the premium rates with at least 60 days prior written notice to the group Contract Holder.

The actuarial information pertaining to this submission is enclosed.

Enclosed also is the required Certification of Readability. We request that a Flesch Score lower than 45.0 be permitted with respect to the Off-Exchange forms pursuant to Insurance Law Section 3102(d), inasmuch as the Off-Exchange forms enclosed use the Department's Model Language.

We request approval of the enclosed forms. We trust that you will find everything in order, and we look forward to your response. If you have any questions regarding this submission, please do not hesitate to contact me at the above mailing address, telephone number or e-mail address.

Sincerely,



Product and Regulatory Approvals

Enclosures

[Aetna Health Inc.]
Explanation of Variability

Healthy New York
Group Contract Amendment Form
HMO/NY HEALTHY HCRSBC-1

General Comments

- The entity name [Aetna Health Inc.] and [Aetna Health Inc. (HMO)] appears within variable brackets so that the name can be updated in the event of an approved name change.
- The term "the Contract Holder" may be replaced with the actual name of the Contract Holder.
- The bracketed titles "*Summary of Benefits and Coverage*" and "*Notices of Material Modifications*" will change to the most current name of the forms.

Amendment Form: HI AGrpAgrHCRsbc 01

1. This amendment will be issued when the Contract Holder's plan is subject to the Federal PPACA requirements regarding the "Summary of Benefits and Coverage" and "Notices of Material Modification".

Certification of Compliance

2. The certification may be required at other intervals other than "on an annual basis" such as "every [2-24] months" or "upon receipt from US of the materials required for distribution". The maximum could also be shown as a "calendar year" or "contract year".
3. When a maximum is shown in "days", it may be changed to the equivalent months and vice versa.
4. The bracketed time period amount for submitting proof is stated in a range. The range reflects Aetna's standard requirement. However, in some instances, a different time period may print in a form issued to a Contract Holder but only if the time period is more liberal to the Contract Holder. Please be assured that this more liberal time period will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Indemnification: *As relating to the Summary of Benefits and Coverage and Notices of Material Modification*

5. This provision is optional and may not print for a Contract Holder.