

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense
Product Name: NY IVL EPO Off-Exchange
Project Name/Number: IVL Off-Exchange filing/

Filing at a Glance

Company: Aetna Life Insurance Company
Product Name: NY IVL EPO Off-Exchange
State: New York
TOI: H15I Individual Health - Hospital/Surgical/Medical Expense
Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical Expense
Filing Type: Off Exchange NG Forms & Rates
Date Submitted: 06/21/2013
SERFF Tr Num: AETN-129085532
SERFF Status: Assigned
State Tr Num: 2013060121
State Status:
Co Tr Num:

Implementation 01/01/2014

Date Requested:

Author(s): [Redacted]

[Redacted]

Reviewer(s): [Redacted]

Disposition Date:

Disposition Status:

Implementation Date:

State Filing Description:

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense
Product Name: NY IVL EPO Off-Exchange
Project Name/Number: IVL Off-Exchange filing/

General Information

Project Name: IVL Off-Exchange filing Status of Filing in Domicile: Not Filed
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type: Individual
 Overall Rate Impact: Filing Status Changed: 06/26/2013
 State Status Changed:
 Deemer Date: Created By: [REDACTED]
 Submitted By: [REDACTED] Corresponding Filing Tracking Number:
 PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
 Include Exchange Intentions: No
 Filing Description:
 This filing covers Individual plans that will be available off the New York Health Benefit Exchange.

Company and Contact

Filing Contact Information

[REDACTED] [REDACTED] [REDACTED]
 [REDACTED]
 [REDACTED] [Phone]
 [REDACTED] [FAX]
 [REDACTED]

Filing Company Information

Aetna Life Insurance Company CoCode: 60054 State of Domicile: Connecticut
 151 Farmington Avenue Group Code: 1 Company Type:
 Hartford, CT 06156 Group Name: State ID Number:
 [REDACTED] [Phone] FEIN Number: 06-6033492

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State Specific

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense
Product Name: NY IVL EPO Off-Exchange
Project Name/Number: IVL Off-Exchange filing/

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

SERFF Tracking #:

AETN-129085532

State Tracking #:

2013060121

Company Tracking #:

State:

New York

Filing Company:

Aetna Life Insurance Company

TOI/Sub-TOI:

H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense

Product Name:

NY IVL EPO Off-Exchange

Project Name/Number:

IVL Off-Exchange filing/

Rate Information

Rate data applies to filing.

Filing Method:

Review and Approval

Rate Change Type:

%

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

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

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense
Product Name: NY IVL EPO Off-Exchange
Project Name/Number: IVL Off-Exchange filing/

Rate Review Detail

COMPANY:

Company Name: Aetna Life Insurance Company
 HHS Issuer Id: 17210
 Product Names: 2014 Individual EPO and MC
 Trend Factors:

FORMS:

New Policy Forms: HIXGR-96801, HIXGR-96809, OffHIXGR-96807, OffHIXGR-96804, OffHIXGR-96810, OffHIXGR-96811
 Affected Forms:
 Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
 Member Months: 0
 Benefit Change:
 Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

Total Earned Premium: 0.00
 Total Incurred Claims:
 Annual \$: Min: Max: Avg:

REQUESTED RATE:

Projected Earned Premium: 97,985,130.00
 Projected Incurred Claims: 77,868,660.00
 Annual \$: Min: 179.00 Max: 2,167.00 Avg: 695.00

SERFF Tracking #:

AETN-129085532

State Tracking #:

2013060121

Company Tracking #:**State:**

New York

Filing Company:

Aetna Life Insurance Company

TOI/Sub-TOI:

H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense

Product Name:

NY IVL EPO Off-Exchange

Project Name/Number:

IVL Off-Exchange filing/

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Manual	HIXGR-96801, HIXGR-96809, OffHIXGR-96807, OffHIXGR-96804, OffHIXGR-96810, OffHIXGR-96811	New		Aetna Individual - 2014 Rate Manual.pdf, Rate Manual - Premium Rates.xlsx,

Aetna Life Insurance Company

New York Individual

Rate Manual

Table of Contents

<u>Description</u>	<u>Page</u>
General	A-1
Premium Rate Manual	A-2 – A-4
Product Summary and Actuarial Values	B-1 – B-18
Plan Forms and Actuarial Value Benefits	C-1 – C-2
Rate Tables	D-1 – D-9
List of Applicable Forms	E-1 – E-3
Commissions Schedule and Incentive Fees	F-1
Loss Ratio	G-1
Marketing and Underwriting	H-1

Aetna Life Insurance Company

New York Individual

General

This rate manual contains worksheets and instructions for calculating the community rates for the New York Individual Plans available from Aetna Life Insurance Company. It is in accordance with Insurance Law Section 3231 (d) Rate Applications and includes rates for Aetna's new products that will be offered effective January 1, 2014.

Aetna Life Insurance Company

New York Individual Premium Rate Manual

The following steps are used to calculate premium rates.

1. 2014 Base Rate

Silver Base Premium Rate
\$610.50

2. Dependent Up to Age 30 Rider

The Federal Health Care Reform allows for continue coverage for dependents on their parent's health plan until age 26. The New York "Age 29" Dependent Coverage Extension permits young adults to continue or obtain coverage under a parent's policy through the age of 29. For subscribers who choose to have the Dependent Up to Age 30 rider, the Silver Base Premium Rate is 3% higher than the rate shown in Step 1 above. The Silver Base Premium Rate with Dependent Up to Age 30 rider is:

Silver Base Premium Rate
\$628.82

3. Plan Pricing Values

The plan factors shown on pages C-1 and C-2 reflect the pricing differential for each product.

4. Standardized Rating Region

The rating regions listed below are based on the required ACA standardized rating regions.

Rating Region	Counties	On/Off-Exchange HIX-Network Product Availability*	Area Factor
Region 1	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	Not Available	0.82
Region 2	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	Not Available	0.90
Region 3	Delaware	Not Available	0.89
Region 3	Dutchess, Orange, Putnam, Sullivan, Ulster	Available	0.89
Region 4	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester	Available	1.00
Region 5	Livingston, Monroe, Ontario, Seneca, Wayne, Yates	Not Available	0.70
Region 6	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins	Not Available	0.79
Region 7	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	Not Available	0.82
Region 8	Nassau, Suffolk	Available	1.00

* Aetna's Individual Segment On/Off-Exchange HIX-network products are available in only the noted areas.

5. **Standardized Census Tiers**

All of Aetna’s New York Individual products will be priced to reflect the following 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. **Child Only Plans**

Aetna will offer one Child Only product in each metal tier. The Child Only rate is set at 41.2% of the corresponding single rate product. For a Child Only plan that covers two children in a family, the premium rate would be twice the one child premium rate. For a Child Only plan that covers three or more children in a family, the premium rate would be three times the one child premium rate, consistent with HHS Regulations.

One Child	Two Children	Three or More Children
0.412	One Child Rate * 2	One Child Rate * 3

7. **Subscriber Rate**

For subscribers without the Dependent Up to Age 30 rider, the subscriber rate is equal to Step 1 x Step 3 x Step 4 x Step 5 or Step 6, rounded to the nearest dollar.

For subscribers who choose the Dependent Up to Age 30 rider, the subscriber rate is equal to Step 2 x Step 3 x Step 4 x Step 5 or Step 6, rounded to the nearest dollar.

The rate tables are shown on pages D-2 to D-9. The applicability period for the rate tables is January 1, 2014 through December 31, 2014.

8. **Examples of Rate Calculations**

Region 3 with NY Aetna Advantage 2000 PD: OAEPO (Base Silver) Plan

Single:

$$\text{Round}(\$610.50 * 1.0 * 0.89 * 1.0,0) = \$543$$

Single + Spouse:

$$\text{Round}(\$610.50 * 1.0 * 0.89 * 2.0,0) = \$1,087$$

Single + Child(ren):

$$\text{Round}(\$610.50 * 1.0 * 0.89 * 1.7,0) = \$924$$

Single + Spouse + Child(ren):

$$\text{Round}(\$610.50 * 1.0 * 0.89 * 2.85,0) = \$1,549$$

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

$$\text{Round}(\$628.82 * 1.0 * 0.89 * 1.7,0) = \$951$$

Single + Spouse + Child(ren) with Dependent Up to Age 30 Rider:
Round($\$628.82 * 1.0 * 0.89 * 2.85,0$) = \$1,595

One Child:
Round($\$610.50 * 1.0 * 0.89 * 0.412,0$) = \$224

Two Children:
Round($\$610.50 * 1.0 * 0.89 * 0.412,0$) * 2 = \$224 * 2 = \$448

Three or More Children:
Round($\$610.50 * 1.0 * 0.89 * 0.412,0$) * 3 = \$227 * 3 = \$672

Region 8 with NY Aetna Advantage 2000 PD: OAEPO (Base Silver) Plan

Single:
Round($\$610.50 * 1.0 * 1.0 * 1.0,0$) = \$611

Single + Spouse:
Round($\$610.50 * 1.0 * 1.0 * 2.0,0$) = \$1,221

Single + Child(ren):
Round($\$610.50 * 1.0 * 1.0 * 1.7,0$) = \$1038

Single + Spouse + Child(ren):
Round($\$610.50 * 1.0 * 1.0 * 2.85,0$) = \$1,740

Single + Child(ren) with Dependent Up to Age 30 Rider:
Round($\$628.82 * 1.0 * 1.0 * 1.7,0$) = \$1,069

Single + Spouse + Child(ren) with Dependent Up to Age 30 Rider:
Round($\$628.82 * 1.0 * 1.0 * 2.85,0$) = \$1,792

One Child:
Round($\$610.50 * 1.0 * 1.0 * 0.412,0$) = \$252

Two Children:
Round($\$610.50 * 1.0 * 1.0 * 0.412,0$) * 2 = \$253 * 2 = \$504

Three or More Children:
Round($\$610.50 * 1.0 * 1.0 * 0.412,0$) * 3 = \$253 * 3 = \$756

Aetna Life Insurance Company

New York Individual

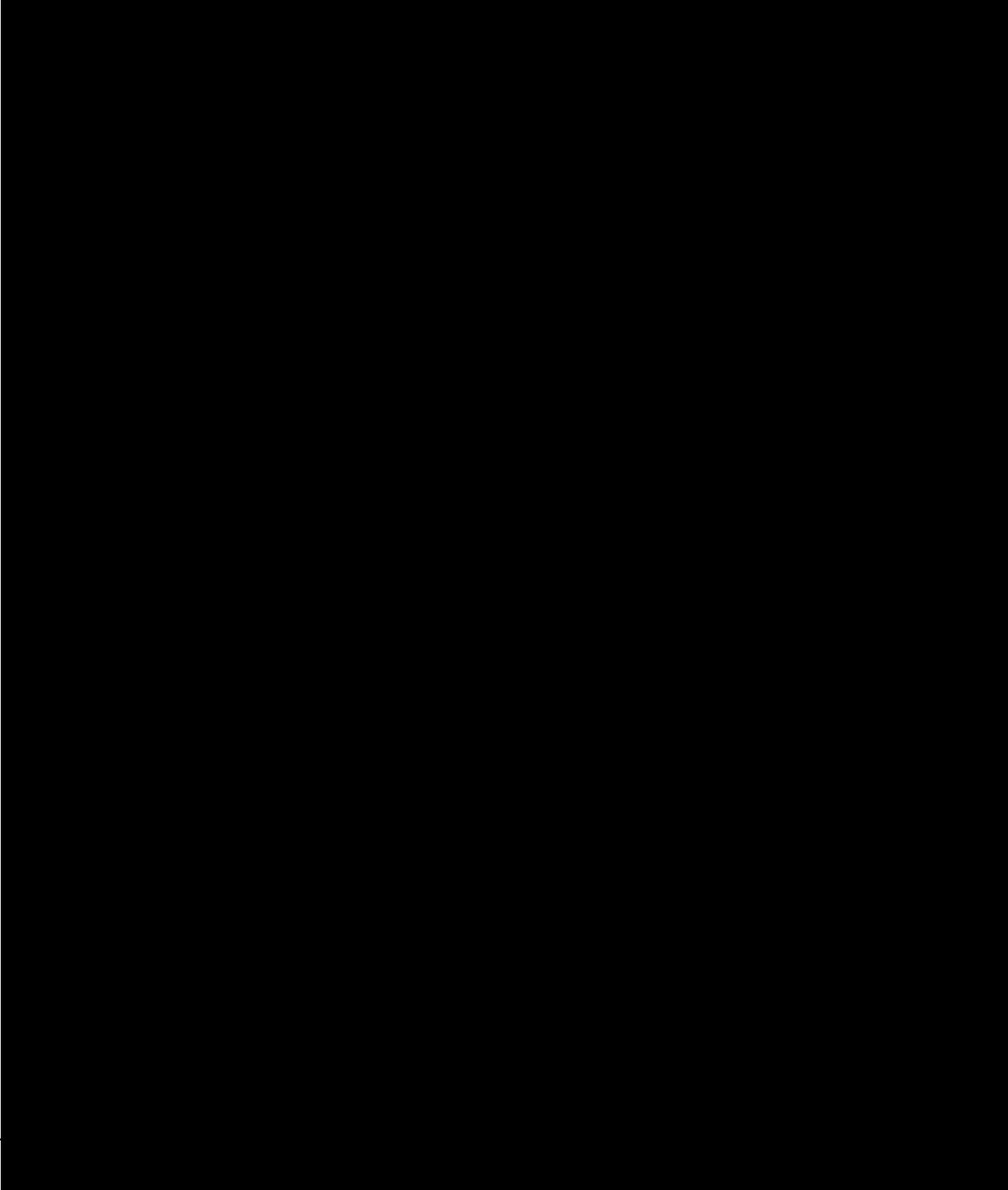
NY AETNA BASIC PD: OAEPO

Summary of Benefits Covered

NY AETNA BASIC PD: OAEPO

New York

Catastrophic Plan



NOT

Aetna Life Insurance Company

New York Individual

NY AETNA ADVANTAGEPLUS 3000 PD: OAEPO

Summary of Benefits Covered

NY AETNA ADVANTAGEPLUS 3000 PD: OAEPO

New York

Bronze Plan

Summary of Features In-Network

Deductible	
Individual	
Family	
Coinsurance	
<i>(Member Responsibility)</i>	
Out-of-Pocket Maximum	
Individual	
Family	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	
Specialist Visit	
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	
Emergency Room Services	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	
Rehabilitative Speech Therapy	
Rehabilitative Occupational and Rehabilitative Physical Therapy	
Preventive Care/Screening/Immunization	
Laboratory Outpatient and Professional Services	
X-rays and Diagnostic Imaging	
Skilled Nursing Facility	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Outpatient Surgery Physician/Surgical Services	
Pharmacy	
Pharmacy Deductible	
Individual	
Family	
Generics	
Preferred Brand Drugs	
Non-Preferred Brand Drugs	
Specialty Drugs (i.e. high-cost)	

NOTE: The plan benefits listed above are identical to the benefits of the Child-Only plans and the Dependent Coverage Up to Age 30 riders.

Aetna Life Insurance Company

New York Individual

NY AETNA PINNACLE PD: OAEPO

Summary of Benefits Covered

NY AETNA PINNACLE PD: OAEPO

New York

Platinum Plan

Summary of Features In-Network

Deductible Individual Family	
Coinsurance <i>(Member Responsibility)</i>	
Out-of-Pocket Maximum Individual Family	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	
Specialist Visit	
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	
Emergency Room Services	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	
Rehabilitative Speech Therapy	
Rehabilitative Occupational and Rehabilitative Physical Therapy	
Preventive Care/Screening/Immunization	
Laboratory Outpatient and Professional Services	
X-rays and Diagnostic Imaging	
Skilled Nursing Facility	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Outpatient Surgery Physician/Surgical Services	
Pharmacy	
Pharmacy Deductible Individual Family	
Generics	
Preferred Brand Drugs	
Non-Preferred Brand Drugs	
Specialty Drugs (i.e. high-cost)	

NOTE: The plan benefits listed above are identical to the benefits of the Child-Only plans and the Dependent Coverage Up to Age 30 riders.

Aetna Life Insurance Company

New York Individual

NY AETNA PINNACLE PD: OAMC

Summary of Benefits Covered

New York

Platinum Plan

Summary of Features		In-Network
Deductible		
Individual		\$0
Family		\$0
Coinsurance (Member Responsibility)		
		\$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum		
Individual		\$2,000
Family		\$4,000
		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)		\$15 per visit
Specialist Visit		\$35 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)		\$500/Admit
Emergency Room Services		\$100 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services		\$15 per visit
Imaging (CT/PET Scans, MRIs)		\$35 per visit
Rehabilitative Speech Therapy		\$25 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy		\$25 per visit
Preventive Care/Screening/Immunization		0%
Laboratory Outpatient and Professional Services		\$35 per visit
X-rays and Diagnostic Imaging		\$35 per visit
Skilled Nursing Facility		\$500/Admit
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		\$100 per visit
Outpatient Surgery Physician/Surgical Services		0%
Pharmacy		In-Network
Pharmacy Deductible		
Individual		\$0
Family		\$0
Generics		\$10
Preferred Brand Drugs		\$30
Non-Preferred Brand Drugs		\$60
Specialty Drugs (i.e. high-cost)		paid at three tier structure

Aetna Life Insurance Company

New York Individual

NY AETNA PINNACLE PD: OAMC

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:

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 (\$)	\$0.00	\$0.00				
Coinsurance (% , Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum (\$)	\$2,000.00					
OOP Maximum if Separate (\$)						

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<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 type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	96.280%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93.750%		<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"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<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

Status/Error Messages: Calculation Successful.

Actuarial Value: 88.1%

Metal Tier: Empire

This product, NY Aetna Pinnacle PD: OAMC, satisfies the HHS guidelines for an Empire plan with an Actuarial Value of 88.1%

Aetna Life Insurance Company

New York Individual

NY AETNA PREMIER 600 PD: OAEPO

Summary of Benefits Covered

NY AETNA PREMIER 600 PD: OAEPO

New York

Gold Plan

Summary of Features	In-Network
Deductible Individual Family	
Coinsurance <i>(Member Responsibility)</i>	
Out-of-Pocket Maximum Individual Family	
Primary Care Visit to Treat an Injury or Illness <i>(excludes Preventative and X-rays)</i>	
Specialist Visit	
All Inpatient Hospital Services <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	
Emergency Room Services	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	
Rehabilitative Speech Therapy	
Rehabilitative Occupational and Rehabilitative Physical Therapy	
Preventive Care/Screening/Immunization	
Laboratory Outpatient and Professional Services	
X-rays and Diagnostic Imaging	
Skilled Nursing Facility	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Outpatient Surgery Physician/Surgical Services	
Pharmacy	
Pharmacy Deductible Individual Family	
Generics	
Preferred Brand Drugs	
Non-Preferred Brand Drugs	
Specialty Drugs (i.e. high-cost)	

NOTE: The plan benefits listed above are identical to the benefits of the Child-Only plans and the Dependent Coverage Up to Age 30 riders.

Aetna Life Insurance Company

New York Individual

NY AETNA ADVANTAGE 2000 PD: OAEPO

Summary of Benefits Covered

NY AETNA ADVANTAGE 2000 PD: OAEPO

New York

Silver Plan

Summary of Features In-Network

Deductible	
Individual	
Family	
Coinsurance	
<i>(Member Responsibility)</i>	
Out-of-Pocket Maximum	
Individual	
Family	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	
Specialist Visit	
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	
Emergency Room Services	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	
Rehabilitative Speech Therapy	
Rehabilitative Occupational and Rehabilitative Physical Therapy	
Preventive Care/Screening/Immunization	
Laboratory Outpatient and Professional Services	
X-rays and Diagnostic Imaging	
Skilled Nursing Facility	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Outpatient Surgery Physician/Surgical Services	
Pharmacy	
Pharmacy Deductible	
Individual	
Family	
Generics	
Preferred Brand Drugs	
Non-Preferred Brand Drugs	
Specialty Drugs (i.e. high-cost)	

NOTE: The plan benefits listed above are identical to the benefits of the Child-Only plans and the Dependent Coverage Up to Age 30 riders.

Aetna Life Insurance Company

New York Individual

SILVER TIER CSR PLANS

The next set of plans have Cost Sharing Reductions (CSR). When ACA provisions go into effect, Individuals who qualify to enroll in CSR plans will receive a cost sharing subsidy from the government that lets them receive a richer benefit plan for the same price that a non-eligible individual pays. To reflect this, different variations of the Silver-tiered product, Aetna Classic PD, were created with varying Actuarial Values. In order to qualify for the CSR plans below, Individuals:

- 1. Must be legally present in the US and not incarcerated*
- 2. Must not be eligible for "affordable" employer-sponsored coverage*
- 3. Must have income that falls within 100%-250% of the Federal Poverty Level*
- 4. Must enroll in a silver plan*

NOTE: The plan benefits listed above are identical to the benefits of the Child-Only plans and the Dependent Coverage Up to Age 30 riders.

Aetna Life Insurance Company

New York Individual

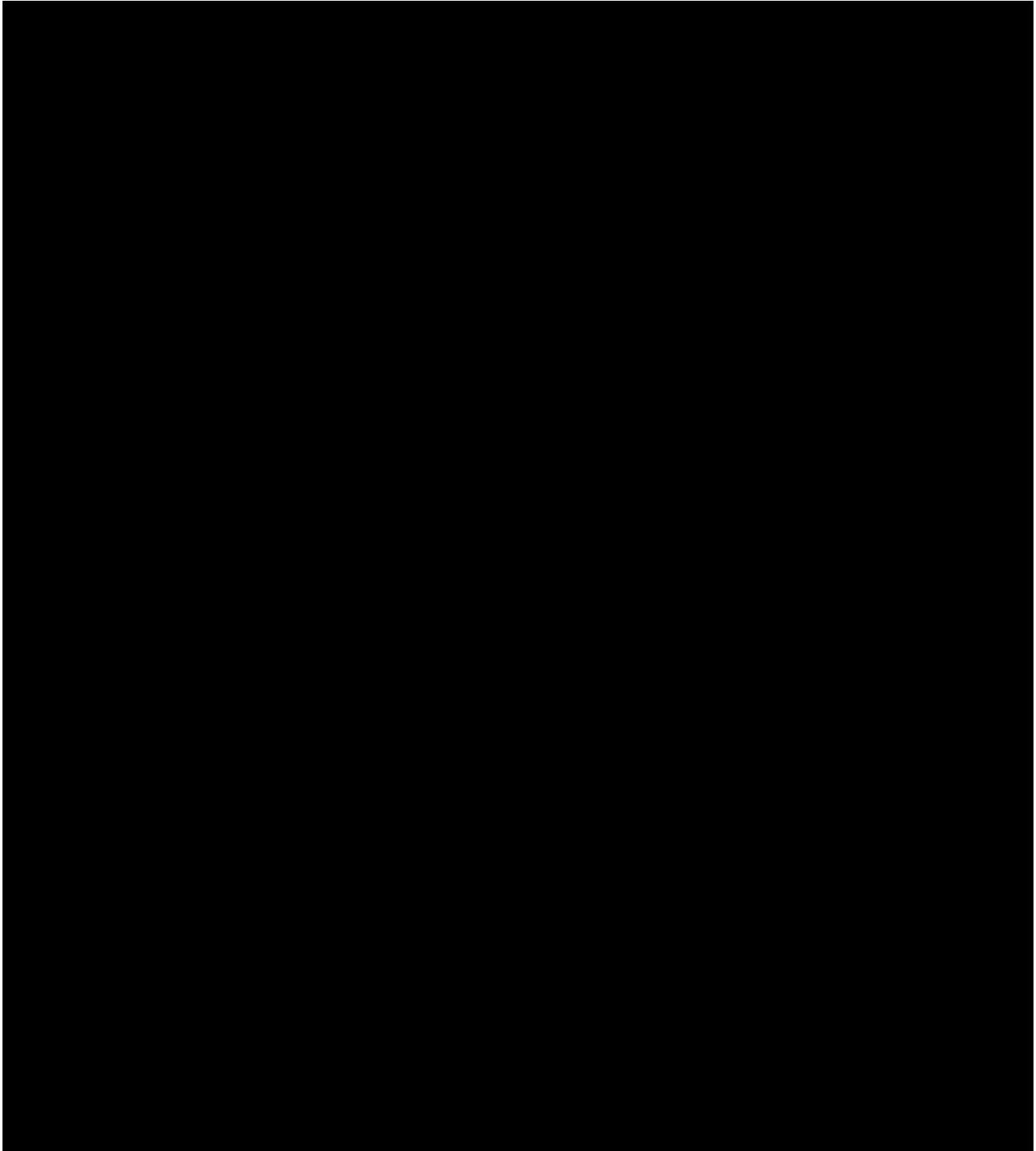
NY AETNA ADVANTAGE 2000 PD: OAEPO CSR 73%

Summary of Benefits Covered

NY AETNA ADVANTAGE 2000 PD: OAEPO CSR 73%

New York

Silver 73% Plan



Aetna Life Insurance Company

New York Individual

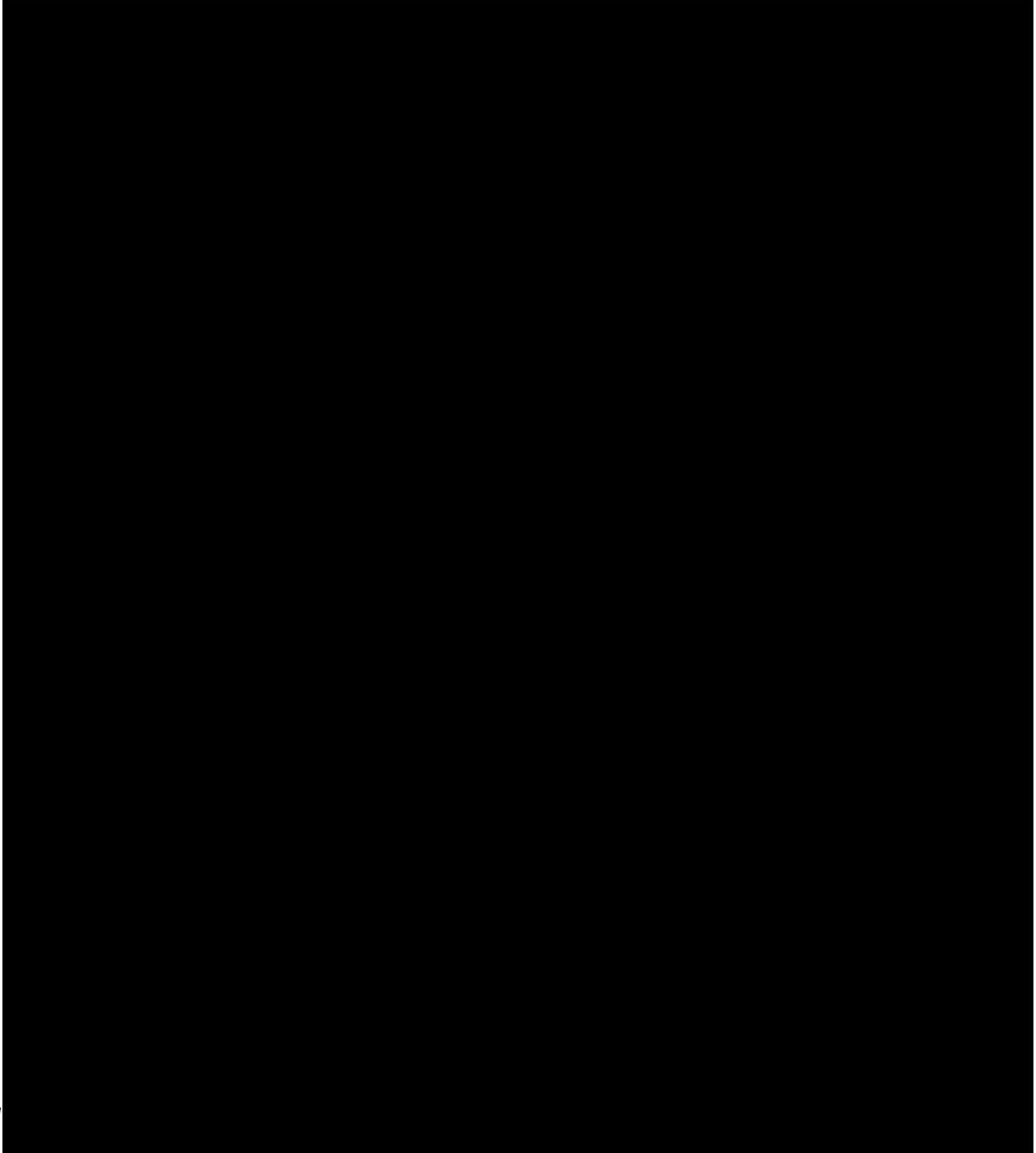
NY AETNA ADVANTAGE 2000: OAEPO CSR 87%

Summary of Benefits Covered

NY AETNA ADVANTAGE 2000 PD: OAEPO CSR 87%

New York

Silver 87% Plan



N

Aetna Life Insurance Company

New York Individual

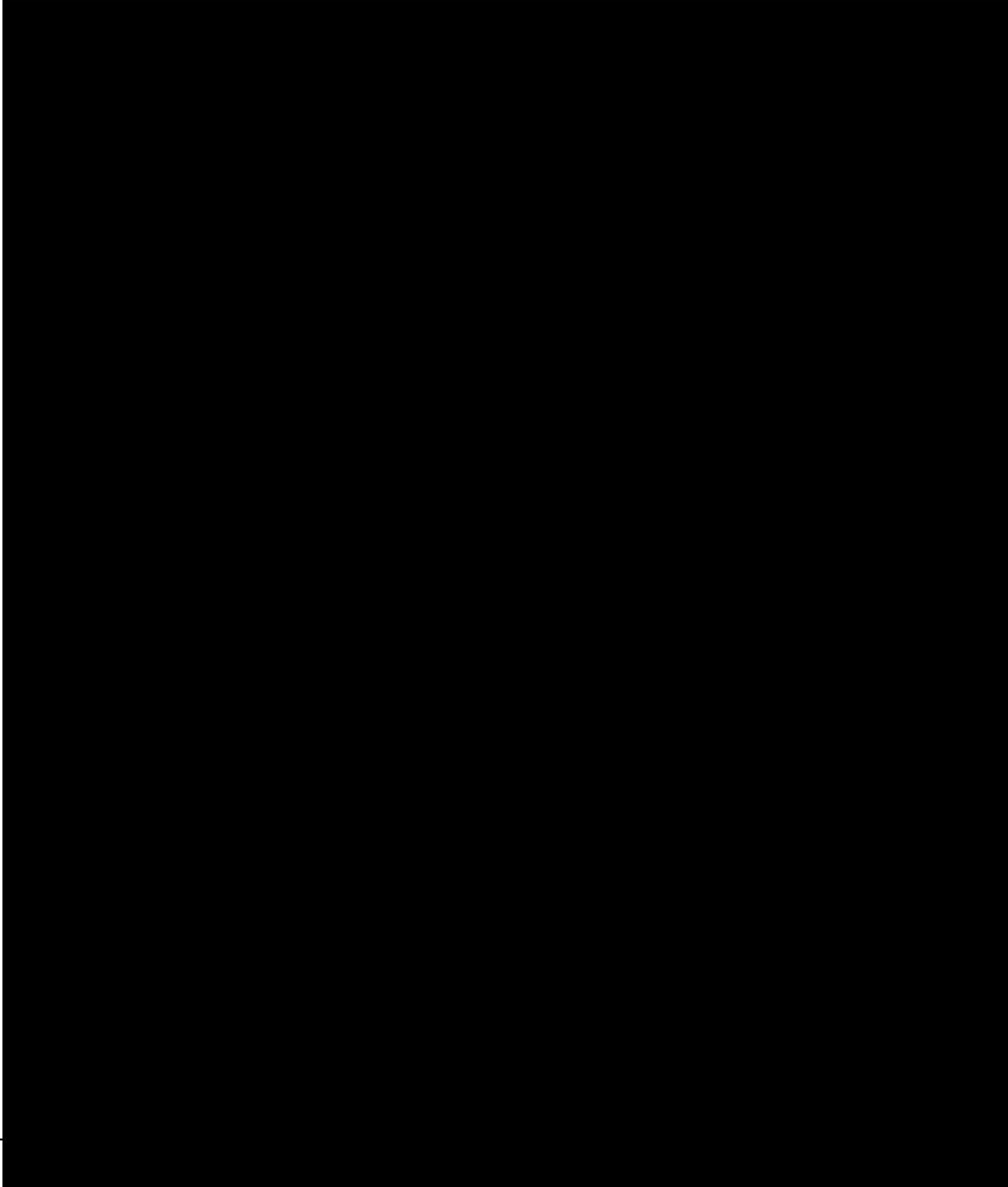
NY AETNA ADVANTAGE 2000 PD: OAEPO CSR 94%

Summary of Benefits Covered

NY AETNA ADVANTAGE 2000 PD: OAEPO CSR 94%

New York

Silver 94% Plan



NOT

Aetna Life Insurance Company

New York Individual

Benefit Plans Form # and Plan-Ids, AV and Pricing Factors

<u>Form #</u>	<u>HIOS Plan-Id</u>	<u>Plan</u>	<u>Exchange</u> <u>ON/OFF</u>	<u>Metallic Tier</u>	<u>Cost - Sharing</u>	<u>Deductible</u>	<u>Actuarial</u> <u>Value</u>	<u>Plan</u> <u>Factors</u>
S2aHIXGR-96807-SB	17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Base	NY_Std_Silver	70.7%	1.0000
G2aOffHIXGR-96807-SB	17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Base	NY_Std_Gold	79.0%	1.1531
P2aOffHIXGR-96807-SB	17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Base	NY_Std_Platinum	88.1%	1.3387
B2aOffHIXGR-96807-SB	17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Base	NY_Std_Bronze	62.0%	0.8594
S2aHIXGR-96810-SB	17210NY0050006	NY Aetna Advantage 2000 PD: OAEPO C/O	OFF	Silver	Base	NY_Std_Silver	70.7%	1.0000
OffHIXGR-96807-Deps Age 29	17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Base	NY_Std_Silver	70.7%	1.0000
B2aOffHIXGR-96810-SB	17210NY0050008	NY Aetna AdvantagePlus 3000 PD: OAEPO C/O	OFF	Bronze	Base	NY_Std_Bronze	62.0%	0.8594
OffHIXGR-96807-Deps Age 29	17210NY0050009	NY Aetna AdvantagePlus 3000 PD: OAEPO DEP 30	OFF	Bronze	Base	NY_Std_Bronze	62.0%	0.8594
P2aOffHIXGR-96810-SB	17210NY0050010	NY Aetna Pinnacle PD: OAEPO C/O	OFF	Platinum	Base	NY_Std_Platinum	88.1%	1.3387

Aetna Life Insurance Company

New York Individual

Benefit Plans Form # and Plan-Ids, AV and Pricing Factors

<u>Form #</u>	<u>HIOS Plan-Id</u>	<u>Plan</u>	<u>Exchange</u> <u>ON/OFF</u>	<u>Metallic Tier</u>	<u>Cost - Sharing</u>	<u>Deductible</u>	<u>Actuarial</u> <u>Value</u>	<u>Plan</u> <u>Factors</u>
[REDACTED] OffHIXGR-96807-Deps Age 29	17210NY0050011	[REDACTED] NY Aetna Pinnacle PD: OAEPO DEP 30	OFF	Platinum	Base	NY_Std_Platinum	88.1%	1.3387
[REDACTED] G2aOffHIXGR-96810-SB	17210NY0050012	[REDACTED] NY Aetna Premier 600 PD: OAEPO C/O	OFF	Gold	Base	NY_Std_Gold	79.0%	1.1531
[REDACTED] OffHIXGR-96807-Deps Age 29	17210NY0050013	[REDACTED] NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Base	NY_Std_Gold	79.0%	1.1531
[REDACTED] P3aOffHIXGR-96804-SB	17210NY0060001	[REDACTED] NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Base	NY_Std_Platinum	88.1%	1.3538

Aetna Life Insurance Company

New York Individual

Premium Rates

Monthly rates for effective dates January 1, 2014 through December 31, 2014 are shown on pages D-2 through D-9.

Aetna Life Insurance Company

New York Individual

Monthly Premium

January 1, 2014 through December 31, 2014

HIOS Plan-Id	Plan	Exchange ON/OFF	Metallic Tier	Rating Area	Tier	Monthly Premium
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 3	Single	\$543
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 3	Single + Child(ren)	\$924
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 3	Single + Spouse	\$1,087
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 3	Single + Spouse + Child(ren)	\$1,549
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 4	Single	\$611
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 4	Single + Child(ren)	\$1,038
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 4	Single + Spouse	\$1,221
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 4	Single + Spouse + Child(ren)	\$1,740
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 8	Single	\$611
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 8	Single + Child(ren)	\$1,038
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 8	Single + Spouse	\$1,221
17210NY0050001	NY Aetna Advantage 2000 PD: OAEPO	OFF	Silver	Region 8	Single + Spouse + Child(ren)	\$1,740
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Aetna Life Insurance Company

New York Individual

Monthly Premium

January 1, 2014 through December 31, 2014

HIOS Plan-Id	Plan	Exchange ON/OFF	Metallic Tier	Rating Area	Tier	Monthly Premium
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 3	Single	\$627
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 3	Single + Child(ren)	\$1,065
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 3	Single + Spouse	\$1,253
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 3	Single + Spouse + Child(ren)	\$1,786
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 4	Single	\$704
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 4	Single + Child(ren)	\$1,197
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 4	Single + Spouse	\$1,408
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 4	Single + Spouse + Child(ren)	\$2,006
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 8	Single	\$704
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 8	Single + Child(ren)	\$1,197
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 8	Single + Spouse	\$1,408
17210NY0050002	NY Aetna Premier 600 PD: OAEPO	OFF	Gold	Region 8	Single + Spouse + Child(ren)	\$2,006
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 3	Single	\$727
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 3	Single + Child(ren)	\$1,237
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 3	Single + Spouse	\$1,455
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 3	Single + Spouse + Child(ren)	\$2,073

Aetna Life Insurance Company

New York Individual

Monthly Premium

January 1, 2014 through December 31, 2014

HIOS Plan-Id	Plan	Exchange ON/OFF	Metallic Tier	Rating Area	Tier	Monthly Premium
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 4	Single	\$817
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 4	Single + Child(ren)	\$1,389
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 4	Single + Spouse	\$1,635
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 4	Single + Spouse + Child(ren)	\$2,329
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 8	Single	\$817
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 8	Single + Child(ren)	\$1,389
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 8	Single + Spouse	\$1,635
17210NY0050003	NY Aetna Pinnacle PD: OAEPO	OFF	Platinum	Region 8	Single + Spouse + Child(ren)	\$2,329
[REDACTED]						
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 3	Single	\$467
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 3	Single + Child(ren)	\$794
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 3	Single + Spouse	\$934
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 3	Single + Spouse + Child(ren)	\$1,331
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 4	Single	\$525
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 4	Single + Child(ren)	\$892
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 4	Single + Spouse	\$1,049
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 4	Single + Spouse + Child(ren)	\$1,495
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 8	Single	\$525
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 8	Single + Child(ren)	\$892
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 8	Single + Spouse	\$1,049
17210NY0050004	NY Aetna AdvantagePlus 3000 PD: OAEPO	OFF	Bronze	Region 8	Single + Spouse + Child(ren)	\$1,495

Aetna Life Insurance Company

New York Individual

Monthly Premium

January 1, 2014 through December 31, 2014

HIOS Plan-Id	Plan	Exchange ON/OFF	Metallic Tier	Rating Area	Tier	Monthly Premium
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 3	Single	\$736
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 3	Single + Child(ren)	\$1,250
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 3	Single + Spouse	\$1,471
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 3	Single + Spouse + Child(ren)	\$2,096
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 4	Single	\$826
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 4	Single + Child(ren)	\$1,405
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 4	Single + Spouse	\$1,653
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 4	Single + Spouse + Child(ren)	\$2,356
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 8	Single	\$826
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 8	Single + Child(ren)	\$1,405
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 8	Single + Spouse	\$1,653
17210NY0060001	NY Aetna Pinnacle PD: OAMC	OFF	Platinum	Region 8	Single + Spouse + Child(ren)	\$2,356

Aetna Life Insurance Company

New York Individual

**Monthly Premium (with Dependent Coverage Up to Age 30 Rider)
January 1, 2014 through December 31, 2014**

HIOS Plan-Id	Plan	Exchange ON/OFF	Metallic Tier	Rating Area	Tier	Monthly Premium
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 3	Single	\$560
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 3	Single + Child(ren)	\$951
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 3	Single + Spouse	\$1,119
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 3	Single + Spouse + Child(ren)	\$1,595
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 4	Single	\$629
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 4	Single + Child(ren)	\$1,069
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 4	Single + Spouse	\$1,258
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 4	Single + Spouse + Child(ren)	\$1,792
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 8	Single	\$629
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 8	Single + Child(ren)	\$1,069
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 8	Single + Spouse	\$1,258
17210NY0050007	NY Aetna Advantage 2000 PD: OAEPO DEP 30	OFF	Silver	Region 8	Single + Spouse + Child(ren)	\$1,792
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Aetna Life Insurance Company

New York Individual

**Monthly Premium (with Dependent Coverage Up to Age 30 Rider)
January 1, 2014 through December 31, 2014**

HIOS Plan-Id	Plan	Exchange ON/OFF	Metallic Tier	Rating Area	Tier	Monthly Premium
17210NY0050011	NY Aetna Pinnacle PD: OAEPO DEP 30	OFF	Platinum	Region 4	Single	\$842
17210NY0050011	NY Aetna Pinnacle PD: OAEPO DEP 30	OFF	Platinum	Region 4	Single + Child(ren)	\$1,431
17210NY0050011	NY Aetna Pinnacle PD: OAEPO DEP 30	OFF	Platinum	Region 4	Single + Spouse	\$1,684
17210NY0050011	NY Aetna Pinnacle PD: OAEPO DEP 30	OFF	Platinum	Region 4	Single + Spouse + Child(ren)	\$2,399
17210NY0050011	NY Aetna Pinnacle PD: OAEPO DEP 30	OFF	Platinum	Region 8	Single	\$842
17210NY0050011	NY Aetna Pinnacle PD: OAEPO DEP 30	OFF	Platinum	Region 8	Single + Child(ren)	\$1,431
17210NY0050011	NY Aetna Pinnacle PD: OAEPO DEP 30	OFF	Platinum	Region 8	Single + Spouse	\$1,684
17210NY0050011	NY Aetna Pinnacle PD: OAEPO DEP 30	OFF	Platinum	Region 8	Single + Spouse + Child(ren)	\$2,399
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 3	Single	\$645
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 3	Single + Child(ren)	\$1,097
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 3	Single + Spouse	\$1,291
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 3	Single + Spouse + Child(ren)	\$1,839
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 4	Single	\$725
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 4	Single + Child(ren)	\$1,233
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 4	Single + Spouse	\$1,450
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 4	Single + Spouse + Child(ren)	\$2,067
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 8	Single	\$725
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 8	Single + Child(ren)	\$1,233
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 8	Single + Spouse	\$1,450
17210NY0050013	NY Aetna Premier 600 PD: OAEPO DEP 30	OFF	Gold	Region 8	Single + Spouse + Child(ren)	\$2,067

Aetna Life Insurance Company

New York Individual

**Monthly Premium (Child-Only)
January 1, 2014 through December 31, 2014**

HIOS Plan-Id	Plan	Exchange ON/OFF	Metallic Tier	Rating Area	One Child Monthly Premium	Two Children Monthly Premium	Three or More Children Monthly Premium
17210NY0050006	NY Aetna Advantage 2000 PD: OAEPO C/O	OFF	Silver	Region 3	\$224	\$448	\$672
17210NY0050006	NY Aetna Advantage 2000 PD: OAEPO C/O	OFF	Silver	Region 4	\$252	\$504	\$756
17210NY0050006	NY Aetna Advantage 2000 PD: OAEPO C/O	OFF	Silver	Region 8	\$252	\$504	\$756
17210NY0050008	NY Aetna AdvantagePlus 3000 PD: OAEPO C/O	OFF	Bronze	Region 3	\$192	\$384	\$576
17210NY0050008	NY Aetna AdvantagePlus 3000 PD: OAEPO C/O	OFF	Bronze	Region 4	\$216	\$432	\$648
17210NY0050008	NY Aetna AdvantagePlus 3000 PD: OAEPO C/O	OFF	Bronze	Region 8	\$216	\$432	\$648
17210NY0050010	NY Aetna Pinnacle PD: OAEPO C/O	OFF	Platinum	Region 3	\$300	\$600	\$900
17210NY0050010	NY Aetna Pinnacle PD: OAEPO C/O	OFF	Platinum	Region 4	\$337	\$674	\$1,011
17210NY0050010	NY Aetna Pinnacle PD: OAEPO C/O	OFF	Platinum	Region 8	\$337	\$674	\$1,011
17210NY0050012	NY Aetna Premier 600 PD: OAEPO C/O	OFF	Gold	Region 3	\$258	\$516	\$774
17210NY0050012	NY Aetna Premier 600 PD: OAEPO C/O	OFF	Gold	Region 4	\$290	\$580	\$870
17210NY0050012	NY Aetna Premier 600 PD: OAEPO C/O	OFF	Gold	Region 8	\$290	\$580	\$870

Aetna Life Insurance Company

New York Individual

**List of Applicable Forms
(On-Exchange)**

Forms

[Redacted content]

Description

[Redacted content]

Aetna Life Insurance Company

New York Individual

**List of Applicable Forms
(On-Exchange Child-Only)**

Forms

[Redacted content]

Description

[Redacted content]

Aetna Life Insurance Company

New York Individual

**List of Applicable Forms
(Off-Exchange)**

Forms	Description
<u>Off-Exchange EPO Policy and Schedules</u>	
OffHIXGR-96807	Policy
OffHIXGR-96807-Deps Age 29	
B2aOffHIXGR-96807-SB	Bronze
S2aOffHIXGR-96807-SB	Silver
G2aOffHIXGR-96807-SB	Gold
P2aOffHIXGR-96807-SB	Platinum
<u>Off-Exchange PPO Policy, OON Rider and Schedule</u>	
OffHIXGR-96804	Policy
OffHIXGR-96804-OON Rider	
P3aOffHIXGR-96804-SB	
<u>Off-Exchange Child-Only EPO Policy and Schedules</u>	
OffHIXGR-96810	Policy
B2aOffHIXGR-96810-SB	Bronze
S2aOffHIXGR-96810-SB	Silver
G2aOffHIXGR-96810-SB	Gold
P2aOffHIXGR-96810-SB	Platinum

Aetna Life Insurance Company

New York Individual

Commissions Schedule and Incentive Fees

The commission schedule for 2014 has not been finalized but we estimate that commissions will average 2% of premium.

Aetna Life Insurance Company

New York Individual

Projected Medical Loss Ratio

The following table summarizes the expected loss ratio including breakdown of the non-claims expense component:

Incurred Claims	83.28%
General Expenses	6.55%
ACA Taxes and Fees	3.33%
Premium Taxes	1.75%
Commissions	2.00%
FIT/SIT* and Profit	3.09%
Total	100.00%

* FIT = Federal Income Tax SIT = State Income Tax

The 2014 projected loss ratio with Federal adjustments is 89.39%. This estimate does not include a credibility adjustment and is based on projected 2014 experience for plans that comply with the ACA market reform requirements. The following table details this calculation.

		Individual	Formula
(a)	Member Months	N/A	
(b)	Premium (pmpm)	\$754.69	
(c)	Medical Cost (pmpm) ⁽¹⁾	\$628.51	
(d)	Medical Benefit Ratio (MBR)	83.28%	= (c) / (b)
(e)	Quality Improvement Activities (pmpm)	\$4.53	= (b) x 0.6 % ⁽²⁾
(f)	Taxes and Fees (pmpm)	\$46.49	= (b) x 6.16% ⁽³⁾
(g)	Adjusted Premium (pmpm)	\$708.21	= (b) - (f)
(h)	Adjusted Claims (pmpm)	\$633.04	= (c) + (e)
	Medical Loss Ratio (MLR)	89.39%	= (h) / (g)

(1) Medical Costs are net of reinsurance recoveries estimated at \$39.70 PMPM (or 5.94% of incurred claims).

(2) Spending on quality improvement activities is estimated to be 0.6% of premium.

(3) Taxes and fees are estimated to be 6.16% of premium.

NOTE: ACA adjustments for QIA and taxes and fees are estimates based on historical experience and projected expenses. Values reflect current actuarial projections and will differ from the final reported MLR. This projection applies to the products included in this filing and is a standalone calculation for the 2014 calendar year. This projection differs from the MLR calculation specified by PPACA which includes three years of experience for all business in the MLR pool.

Aetna Life Insurance Company

New York Individual

Outline of General Underwriting and Marketing Methods

Aetna Life Insurance Company offers its comprehensive health care benefits to the residents of New York. Aetna Life Insurance Company offers traditional community rated contracts to Individuals with no preexisting condition limitations or benefit waiting periods. Aetna Life Insurance Company makes available to Individual products and rates that are filed and approved, and compliant with all insurance laws, regulations and practices in the state of New York.

Some of these plans listed on pages C-1 and C-2 will be made available through the New York Health Benefit Exchange. Other plans will be marketed through brokers and general agents, and directly to consumers through direct mail, telemarketing, and the internet.

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations. Aetna may rely on information provided by the New York Health Benefit Exchange as verification of eligibility.

SERFF Tracking #:

AETN-129085532

State Tracking #:

2013060121

Company Tracking #:

State:

New York

Filing Company:

Aetna Life Insurance Company

TOI/Sub-TOI:

H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense

Product Name:

NY IVL EPO Off-Exchange

Project Name/Number:

IVL Off-Exchange filing/

Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	
Attachment(s):	ah_indSHOP_2013.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Read Cert IVL Off..pdf
Item Status:	
Status Date:	

Bypassed - Item:	Explanation of Variability
Bypass Reason:	As requested, we have removed the Explanations of Variability applicable to Off-Exchange plans, which are being submitted under separate cover.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	NY Individual_Memorandum_2014_HIX.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	URRT Part III IVL - NY.pdf
Item Status:	
Status Date:	

SERFF Tracking #:

AETN-129085532

State Tracking #:

2013060121

Company Tracking #:

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense
Product Name: NY IVL EPO Off-Exchange
Project Name/Number: IVL Off-Exchange filing/

Satisfied - Item:	Actuarial Value Calculations
Comments:	Please see pages B1 to B14 and C1 of the Rate Manual for the AV calculation result.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 1-General Information
Comments:	
Attachment(s):	NY Exhibit 1.pdf NY Exhibit 1.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 7-Historical Data
Comments:	
Attachment(s):	NY Exhibit 7.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 8-Adjustment Factors to Index Rate
Comments:	
Attachment(s):	NY Exhibit 8.pdf NY Exhibit 8.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 9-Summary of Administrative Expenses
Comments:	
Attachment(s):	NY Exhibit 9.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit A - Rate development summary
--------------------------	--------------------------------------

SERFF Tracking #:

AETN-129085532

State Tracking #:

2013060121

Company Tracking #:**State:**

New York

Filing Company:

Aetna Life Insurance Company

TOI/Sub-TOI:

H151 Individual Health - Hospital/Surgical/Medical Expense/H151.001 Health - Hospital/Surgical/Medical Expense

Product Name:

NY IVL EPO Off-Exchange

Project Name/Number:

IVL Off-Exchange filing/

Comments:	
Attachment(s):	NY Exhibit A-1 - Rate Development.pdf NY Exhibit A-1 - Rate Development.xlsx NY Exhibit A-2 - Rate Development Summary.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit B - Trend
Comments:	
Attachment(s):	NY Exhibit B - Trend.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Compliance Certification
Comments:	
Attachment(s):	NY Compliance Certification.pdf
Item Status:	
Status Date:	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Individual Health Benefits Exchange Checklist

As of 5/02/13

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. **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 or contract and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, please select the link labeled “ISC”.

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

LINE OF BUSINESS: **Individual Exchange**

	<u>TOI</u>	<u>LINE(S)</u>	<u>OF INSURANCE</u>	<u>Sub-TOI</u>
HOrg021		Individual Health	Health Organization Maintenance (HMO)	rg021.005B Individual POS rg021.005D Individual HMO
Individual Health		Major H16	Medical H16	1.005A Individual PPO 1.005C Individual Other
Individual Health			Hospital Surgical Medical Expense	H15I.001 Health
H06		Health	Conversion H06.0	00 Conversion

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

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS	<i>Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department of Financial Services Circular Letters and OGC opinions</i>	<i>Note: This checklist is intended to provide guidance in the preparation of policy forms for submission and is not intended as a substitute for statute or regulation.</i>	Form/Page/Para Reference
Complete Policy or Contract Submission or Pages/Rider/Endorsement	§4306(d) §4306(e) §3102(c)	This submission contains a complete policy or contract form. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No statement by the individual in his application for a contract or policy shall avoid the contract or be used in legal proceedings thereunder, unless such application or an exact copy thereof is included in or attached to such contract.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>No agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions. <i>Note: If this contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the insurer a part of the contract, such portion shall be set forth in full.</i></p> <p>If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes <input type="checkbox"/> No <input type="checkbox"/> (If no is checked, explain in the space provided above.)</p> <p>This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.</p>	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	<p>Each form in the filing must meet the following requirements:</p> <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. 	Complies
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)	<p>The filing must include a SERFF filing description or a letter of submission that contains the following:</p> <ul style="list-style-type: none"> • The identifying form number of each form submitted. §52.33(a) • 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) 	Letter included
Discrimination	§2606 §2607 §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, or marital status.	Complies

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

APPLICATION FORMS	Model Language		Form/Page/Para Reference
Model Application Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	
Prohibited Questions and Provisions	§3216(c)(5)(a) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy 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 void. An agreement that acceptance of any policy 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).	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	
Free Look	§4306 §3216(c)(10)	This contract or policy contains a "free look" provision that is for a period of not less than 10 days and not more than 20 days.	
Brief Statement	§4306(m)	This contract or policy contains a brief description of the contract on its first page.	
Table of Contents	§3102(c)(1)(G) Model Language	A table of contents is required.	
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
DEFINITIONS	§ 3217 Model Language	<i>Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.</i>	Form/Page/Para Reference
Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Services Performed at	§4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Comprehensive Care Center for Eating Disorders	§4328	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 Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: <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			
Preauthorization Requirements Model Language Used?	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b)	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	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	\$500.00, whichever is less, is permissible.	
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of “medical necessity” used in determining whether benefits will be covered.	
Contact Information Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(16) §4324(a)(16) PHL §4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer’s network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	N/A
Specialty Care Provider as PCP Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) 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.	N/A
Standing Referrals Model Language Used? Yes <input type="checkbox"/> No <input checked="" 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.	N/A
Specialty Care Center Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) 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.	N/A
Transitional Care When A Provider Leaves the Network	§4804(e) §3217-d(c) §4306-C(c)	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	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>PHL §4403(6)(e) Model Language</p>	<p>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>	
<p>Transitional Care For A New Member in a Course of Treatment</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language</p>	<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 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.</p>	
<p>COST-SHARING EXPENSES AND ALLOWED AMOUNT.</p>			
<p>Cost of Service</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3201(c)(3) 11 NYCRR 52.1(c) Model Language</p>	<p>If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.</p>	
<p>Reimbursement of Providers</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language</p>	<p>This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.</p>	
<p>Non-Participating Providers and Non-Authorized Services</p>	<p>§3217-a(a)(6) §4324(a)(6) PHL §4408(1)(f) Model Language</p>	<p>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.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
ELIGIBILITY Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	For each of the following eligibility provisions model language <u>must</u> be used.	Form/Page/Para Reference
Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	
Spouse	§4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	
Dependents	§4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, 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>	
Unmarried Disabled Children	§4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, 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. <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>	
Newborn Infants	§4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, 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 60 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. <i>Note: In the case of Individual or Individual and Spouse 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 are required to make coverage effective for a newborn infant, the</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>coverage may provide that such notice and/or payment be made within no less than 60 days of the day of birth to make coverage effective from the moment of birth.</i>	
Adopted Children and Step-Children	11NYCRR52.17(a)(30) , (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners	§4304(d)(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. 	
Enrollment Periods	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	Standard Benefit Design Description Chart	<i>The following benefits <u>must</u> be included in the policy or contract form.</i> Standard Products: Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p><u>Non-Standard Products:</u> 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 a higher number of covered visits or days; 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 The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative</p>	
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: <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>	
Federally Mandated Preventive Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: <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>	
Cervical Cytology Screening	§4328 §3216(i)(15)	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	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>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>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(11) §4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes the following coverage for mammography screening for occult breast cancer:</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 §4328 §3216(i)(10) §3216(l)</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>§3216(l) §4328 § 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. 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		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	
Prostate Cancer Screening Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: <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 • 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			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(24) §4303(aa) Model Language	<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. 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<ul style="list-style-type: none"> • 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>§4328 §4303(a)(2) §3216(i)(9) §3217-a(a)(8) §4900(c) §4303(a)(2) Circular Letter No.1 (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>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 that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. <p><i>Note the following definitions must be used:</i></p> <p><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</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<i>a newborn child (including the placenta).</i>	
Urgent Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l)	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.	
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT 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 §4328 §3216(l) 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 §4328 §3216(l) 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 §4328 §3216(l) 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"/>	§3216(i)(21) §4328 §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	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<p>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.</p> <p><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></p>	
<p>Dialysis Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language</p>	<p>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 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><i>Note: Substitution and the addition of benefits to EHB categories are only</i></p>	<p>§4328 §3216(l) 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> <p><i>Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per condition; cover visits per year rather than per condition; and may remove the lifetime limit.</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p><i>permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" 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 Standard benefit in the space provided.</p>			
<p>Non-Standard Benefit explanation:</p>			
<p>Home Health Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(6) §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><i>Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Interruption of Pregnancy</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l) 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 for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.</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>§4328 §3216(i)(13) §4303(s) 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 for Non-Standard Products. 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; 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 §4328 §3216(i)(15-a)(A) §3216(l) 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 §4328 §3216(l) 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?</p>	<p>45 CFR § 156.100 §4328 §3216(l)</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>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Outpatient Hospital Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Preadmission Testing Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(7) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Outpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" 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 Standard	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. <i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i> 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 undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: <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. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>Note: Non-standard Exchange 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</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

benefit in the space provided.		<i>hospitalization or surgery.</i>	
<u>Non-Standard Benefit explanation:</u>			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(19)(A)(i) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. <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. 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.	
Second Surgical Opinion Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §3216(i)(8) §4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Mandatory Second Surgical Opinion Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4303(b) §4328 Circular Letter No. 29 (1979) Model Language	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). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	
Second Opinion in Other Cases Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Surgical Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 §3216(l) 11 NYCRR § 52.6	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	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	Model Language	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.	
Oral Surgery Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 11 NYCRR§52.16(c)(9) §4328 §3216(l) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: <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>	
Mastectomy Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(l) §3216(i)(20) §4328 §4303(v) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Post Mastectomy Reconstruction Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(20) §4328 §4303(x) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	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 symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	
Transplants Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §3215(l) §4328 Model Language	This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
<p>Autism Spectrum Disorder</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(25) 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 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> <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>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Diabetes Equipment, Supplies and Self-Management Education</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(i)(15-a) §4328 §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 §§ 3216(i)(15-a) 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: For Standard Products, the medical benefit cost-sharing must apply. For Non-Standard Products, either a medical or a prescription benefit, may apply 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 §3216(l) §4328 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 §4328 §3216(l) 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 the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</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 malfunctions. <i>{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Hospice Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §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: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan 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 §3216(l) §4328 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 the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.</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>	
<p>Hospital Services</p>	<p>11NYCRR§52.5 45 CFR § 156.100</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>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 Model Language</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>§3216(i)(10) §4328 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 §3216(i)(10), 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> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		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 §3216(l) §4328 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"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i> Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" 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 Standard benefit in the space provided.	45 CFR § 156.100 §3216(l) §4328 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: The Standard Exchange Plan must cover 60 days. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also 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>Non-Standard Benefit explanation:</u>			
Skilled Nursing Facility Model Language Used?	§3216(i)(6) §4328 §4303(d)	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.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 Model Language	<p><i>Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
End of Life Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language	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.	
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §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	<p>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.</p> <p><i>Under MHPAEA, individual 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></p>	
Outpatient Mental Health Care Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(4) §4328 §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental	<p>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 §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	<p>Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language</p>	<p>MHPAEA.</p> <p><i>Under MHPAEA, individual 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 treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
<p>Inpatient Substance Use Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3216(l) §4328 §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>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>§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009)</p>	<p>This policy 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</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

	<p>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>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> <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, individual 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 §3216(l) §4328 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>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		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.	
Enteral Formulas Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited 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"/>	§3216(i)(12) §4328 §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"/>	§4328 §3216(l) §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	§4328 §3216(l) §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"/>	§4328 §3216(l) §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.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Orally Administered Anticancer Medications</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(i)(12-a)(A) §4303(q-1) Model Language</p>	<p>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.</p>	
<p>Mail Order Drugs for Policies or Contracts With a Provider Network</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(hh) Model Language</p>	<p>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.</p>	
<p>Contraceptive Drugs and Devices</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4328 §3216(l) §4303(cc) 42 USC §300gg-13 Model Language</p>	<p>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. Contraceptive coverage must be provided with no cost-sharing.</p> <p><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></p>	
<p>WELLNESS</p>	<p>45 CFR § 156.100 §3239</p>		
<p>Exercise Facility Reimbursement</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p><i>Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.</i></p> <p>Non-Standard Product? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p>45 CFR § 156.100 §3239 §4328 §3216(l) Model Language</p>	<p>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.</p> <p>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.</p> <p><i>Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p><i>Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.</i></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.</p>			
<p><u>Non-Standard Benefit explanation:</u></p>			
<p>Other Wellness Benefits</p> <p>Is this a Standard Exchange Plan? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, Additional Wellness Benefits may not be offered.</p>	<p>45 CFR § 156.100 §3239 §4328 §3216(l)</p>	<p>Additional Wellness Benefits may not be covered under a standard Exchange plan but may be covered under a non-standard Exchange plans. All additional wellness benefits <u>must</u> comply with § 3239 of Insurance Law.</p>	
<p>VISION CARE</p>			
<p>Pediatric Vision Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l)</p> <p>Model Language</p>	<p>This policy or contract form provides coverage for pediatric vision care including: emergency, 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>	
<p>DENTAL CARE</p>			
<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 this QHP filing? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 §4328 §3216(l)</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>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<u>Explanation:</u>			
ADDITIONAL BENEFITS		Additional benefits may be covered in the non-standard Exchange plans only.	
Family Vision Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	
Orthotics Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people’s fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	
<u>Explanation:</u>			
Acupuncture		This policy or contract form provides coverage for acupuncture.	
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.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

<p>Cosmetic Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(5)) 11NYCRR56 Model Language</p>	<p>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.</p>	
<p>Coverage Outside of the United States, Canada or Mexico</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(12) Model Language</p>	<p>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.</p>	
<p>Dental Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(9)) Model Language</p>	<p>This policy or contract form excludes coverage for dental services except for: care or treatment due to 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.</p>	
<p>Experimental or Investigational Treatment.</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4303(z) Article 49 Model Language</p>	<p>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.</p>	
<p>Felony Participation</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(4))(i) Model Language</p>	<p>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.</p>	
<p>Foot Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(6)) Model Language</p>	<p>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.</p>	
<p>Government Facility</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(8)) Model Language</p>	<p>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.</p>	
<p>Medically Necessary</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3201(c)(3) Article 49 Model Language</p>	<p>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.</p>	
<p>Medicare or Other</p>	<p>11NYCRR52.16(c)(8)</p>	<p>This policy or contract form excludes coverage for services if benefits are provided for such services</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Governmental Program Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>) Model Language	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.	
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 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.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

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	§3216(d)(1)(E) 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"/>	§3216(d)(1)(G) §4306(n) 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.	
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)(g) PHL § 4408-a 10NYCRR98-1.14 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; 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		<ul style="list-style-type: none"> 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. 	
TERMINATION OF COVERAGE Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language §4306(c) §4304(c)	<i>The following are the only termination provisions permissible under the Insurance Law.</i> <i>The model language must be used for each of the following termination provisions.</i>	Form/Page/Para Reference
Notice of Termination	11 NYCRR 52.17(a)(25)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	
Termination for Failure to Pay Premiums	§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the 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. Insurers provide a grace period of at least three consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one full month's premium during the benefit year.	
Reinstatement Following Default	§4306(g) §3216(d)(1)(D)	This policy or contract form includes a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the 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.	
Discontinuation of a Class of Coverage	§4304(c)(2)(C) §3216(g)(1)(F)(2)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each subscriber and beneficiary not less than 90 days for	

**NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist**

		plans subject to Article 32 of the Insurance Law, or 5 months for plans subject to Article 43, prior to the date of discontinuance. The insurer must offer individuals the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer 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 individuals or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	
Discontinuation of all Policies/Contracts in the Individual Market (Applicable to non-HMOs only)	§4304(c)(2)(C)(ii) §3216(g)(1)(D)	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 individual market upon written notice to the superintendent and to each subscriber, participant, and beneficiary at least 180 days prior to the date of discontinuance.	
Termination if there are No Longer Insureds in the Insurer's Service Area	§4304(c)(2)(D) §3216(g)(1)(E)	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.	
Termination for Spouses in cases of divorce	§3216(g)(1)(F)	This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	
Termination upon death of Subscriber	§3216(g)(1)(F)	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 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	§3216(g) §4304(b)(2) 11 NYCRR 52.17(a)(2)	This policy or contract provides that except as specified in §3216(g), or §4304(b)(2) the insurer must renew or continue in force such coverage at the option of the subscriber. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	
Premiums	§4306(a) §3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the subscriber 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	11 NYCRR 52.17(a)(15) Model Language	If the covered persons' coverage terminates, an extended benefit will be provided 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.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Suspension of Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: <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. 	
Conversion - Right to a New Contract After Termination Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4306(i) §3216(c)(5)	This policy or contract form provides that (a) if an individual is no longer covered under a “family policy or contract” because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e. bronze, silver, gold, or platinum) that covers all benefits required by state and federal law. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the “family policy or contract” or whose young adult coverage terminates. 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.	
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4306 §3216(d)(1)(B)(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"/>	§4306(e) §3216(d)(1)(A) 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 subscriber and insurer.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

Action in Law or Equity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	PHL §4406-a §3216(d)(1)(K) 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 three 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) Model Language	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).	
Unilateral Modification Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11 NYCRR52.17(a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	
Non-English Speaking Insureds Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	PHL §4408(1)(p) §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"/>	Standard Benefit Design Description Chart Model Language	This policy or contract <u>must</u> contain a Schedule of Benefits. All services subject to preauthorization <u>must</u> be clearly indicated in the Schedule of Benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4328 §4306-e §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"/>	§4328 §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	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		responsibility for non-covered health care procedures, treatment or services.	
ADDITIONAL RIDERS			
<p>Out-of-Network Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>If Out-of-Network coverage is offered please answer the following:</p> <p>Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract <input type="checkbox"/> Rider <input checked="" type="checkbox"/></p>	<p>Model Language</p>	<p>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.</p> <p><i>Note: The Department will not approve 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></p>	
<p>Extended Dependent Coverage</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4304(d)(1)(B) §3216(a)(4)(C) Model Language</p>	<p>For Parent and Child/Children and/or Family coverage, this policy or contract form must make available and if requested by the subscriber or policyholder, 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 § 3216(a)(4)(C) or 4304(d)(1)(B).</p>	
PROVIDER NETWORKS	<p>§3201(c)</p>	<p>The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.</p>	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		<p>PLEASE NOTE: A new and detailed set of instructions “Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans” will be 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	<p>11NYCRR52.40(a)(1)</p>	<p>Actuarial qualifications:</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

MEMORANDUM)	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	§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Individual: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio <input type="text"/> %.	
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	
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.	
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: <input type="text"/> %.	
RATE MANUAL	11NYCRR52.40(c)(2)) §3231(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		<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>	F
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1))	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Individual Health Benefits Exchange Checklist

		b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	11NYCRR52.40(d)(2)	<ul style="list-style-type: none"> a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. b. History of previous New York rate revisions. c. Description, in detail, of policy benefits. d. Provide complete annual and total New York and nationwide claims experience respectively, since inception, including: <ul style="list-style-type: none"> (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. e. Derivation of the proposed rate revision in detail, including: <ul style="list-style-type: none"> (i) Demonstration that the expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosed loss ratio (ii) Actuarial justification of proposed rates revision (increase/decrease) f. Non-claim expense components as a percentage of gross premium. g. Impact on rates as a result of each of the changes with actuarial justification. h. Expected loss ratio(s) after the proposed changes. 	
Actuarial Certification	11NYCRR52.40(a)(1)	<ul style="list-style-type: none"> a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. 	
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: <input type="text"/> %.	
REVISED RATE MANUAL PAGES	11NYCRR52.40(c)(2)	<ul style="list-style-type: none"> 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, issue limits, and renewal conditions. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s). 	

Name of Company Aetna Life Insurance Company

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



Officer's Title

Date May 13, 2013

SWH/al

Aetna Life Insurance Company

<u>Form #</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables</u>	<u>Flesch Score*</u>
OffHIXGR-96807				33.4
OffHIXGR-96810				33.2
OffHIXGR-96804				33.2
OffHIXGR-96811				33.2
OffHIXGR-96804 OON Rider				31.6
OffHIXGR-96811 OON Rider				31.6
OffHIXGR-96807-Deps Age 29				51.8
OffHIXGR-96804-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.

Aetna Life Insurance Company

**Policy Forms: HIXGR-96801, HIXGR-96809, OffHIXGR-96807,
OffHIXGR-96804, OffHIXGR-96810, OffHIXGR-96811**

HIOS Product ID: 17210NY005

SERFF Tracking Number: AETN-129003886

Actuarial Memorandum

Comprehensive Individual Medical Expense Benefit Plans

1. Purpose, Scope, and Effective Date

The purpose of this filing is to request approval of the monthly premium rates for the policy forms referenced above. The development of these rates reflects the impact of the market changes and rating requirements resulting from PPACA and subsequent regulation.

These rates are for plans issued in the individual market in conjunction with our Qualified Health Plan (QHP) application in New York beginning January 1, 2014. The rates comply with all rating guidelines under federal and state regulation. The filing covers plans that will be available on and off the New York Health Benefit Exchange.

2. Key Assumptions

The rates in this filing were developed using the following assumptions:

- New York will expand Medicaid eligibility
- New York will not have a supplemental reinsurance program
- The financing for the New York Health Benefit Exchange will not come from the premiums on health benefit plans described in this rate filing.

The proposed rates are dependent upon these assumptions and may not be appropriate if these assumptions prove to be materially different from how the 2014 market emerges.

3. Lack of Final Guidance

The descriptions and analysis presented in this rate filing reflect our understanding of regulations and guidance issued through April 4, 2013. As further guidance and information is received, we reserve the right to submit revisions or withdraw our filing entirely.

4. Benefit Design

This filing includes the following standard plans: one Catastrophic, one Bronze, one Silver, one Gold, and one Platinum. The Catastrophic plan will only be available through the New York Health Benefit Exchange. All other standard plans will be offered outside the New York Health Benefit Exchange. We will also be offering one Platinum plan with Out-of-Network coverage.

Please refer to the corresponding policy forms for detailed benefit language. Information on the cost-sharing parameters of the covered benefit plans, including deductibles, copays, and Actuarial Values, is summarized on pages B-1 to B-19 of the rate manual. All benefit and cost sharing parameters comply

with New York benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

5. Catastrophic Plan

The average morbidity level for the Catastrophic plan is estimated to be approximately 25% lower than that of a similar Bronze plan. This adjustment is reflected in the plan factors shown on page C-1 of the rate manual.

6. Marketing

As described above, some of these plans will be made available through the New York Health Benefit Exchange. In addition, plans will be marketed through brokers and general agents, and directly to consumers through direct mail, telemarketing, and the internet.

7. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations. Aetna may rely on information provided by the New York Health Benefit Exchange as verification of eligibility.

8. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

9. Experience

This filing is for new policy forms. There is no applicable experience for these products to be offered in 2014. We used the Small Group PPO experience in our rate development.

As shown in Exhibit A-1, we applied a factor of 1.1970 which represents the ratio of post-ACA Individual morbidity to the post-ACA Small Group morbidity. This morbidity ratio was taken from a study conducted by an outside consulting company. The contents of the study are proprietary.

Incurred claims used in the rate development include a provision for claims incurred but not reported (IBNR). The IBNR reserve is estimated using actuarial principles and assumptions that consider 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 include three months of runoff to reduce the reliance on reserve estimates for the most recent months. The IBNR reserves represent approximately 2.1% of claims for our individual business during the experience period.

10. Medical Trend and Provider Network

Our pricing model makes the following adjustments to normalize the premium and claims and assure the numerator and denominator of the loss ratio calculation are based on the same populations and mix of plan designs:

- We utilized Aetna Small Group, community rated NY EPO and MC experience for the period 10/01/2011 through 09/30/2012 with run-out through 12/31/2012 in order to project claims for this

filing. No adjustments were made for large claims. There have been no changes in tier relationships, the single conversion factor, or area factors.

- 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.

The medical trend assumptions are based on our small group EPO and MC experience. For this rate filing, Exhibit B shows that we used 11.8% 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.

11. Claims Development and Morbidity Adjustments

The development of these rates involves a projection of who will be covered and at what cost in 2014. We have used available models and tools to accomplish this and shown, in our judgment, what the various components are worth relative to the final premium.

The projected claim level was based on our 10/1/2011-09/30/2012 experience of Aetna's Small Group block of PPO business in New York. The base claims in the benchmark silver plan is \$540.54. The development of this is discussed in Exhibits A-1 and A-2.

12. Retention

The Retention Portion of the Market Base Rate is 16.72%. This was developed from the following items:

1. Taxes and Fees of 6.16% comprised of:
 - a. Premium Taxes of 1.75%
 - b. Patient Centered Outcomes Research Fund of \$0.15 per member per year, converted to 0.02%
 - c. Reinsurance Contribution of \$5.25 PMPM, converted to 0.70%
 - d. Health Insurer Fee of 2.60%
 - i. 1.70% paid post-tax as the Health Insurer Fee
 - ii. 0.90%, charged as a corporate tax of 35% on the 2.60% pre-tax charge
 - e. Exchange User Fee of 0%
 - f. Federal Income Tax of 1.08%, assuming 35% tax rate
 - g. Risk Adjustment Program Fee of 0.01%
2. Commissions of 2% of premium
3. General Administrative Expenses of \$49.43, converted to 6.55% of premium based upon an expected average premium level

Of the above total general administration expenses,

- a. 0.60% is classified as Quality Improvement Activities under 45 CFR Part 158.
 - b. Salaries and employee benefits and welfare programs are 50% of total general administration expenses
 - c. Licensing Fees are 0.20%
4. Risk Charge of 2.01%

These prospective expenses are based on historical expense levels and the changes expected with the requirements of PPACA and the New York Health Benefit Exchange.

The Risk Charge of 3% is in line with the amount allowed in the Risk Corridor calculation. Aetna is applying for QHP certification on these plans in New York in order to benefit from this program.

13. Market Base Premium Rate

The market base premium rate is \$610.50.

14. Risk Adjustment, Reinsurance, and Risk Corridors

As discussed below, we developed a market base premium rate representative of the average market morbidity expected in 2014. We believe the proposed rates are consistent with a market-average risk profile and anticipate that any risk adjustment will approximate the actual deviation in claims from the projected market-average level.

As noted in Line 15 of Exhibit A-1, we expect the transitional reinsurance program to reduce the average claims for these products by approximately 5.94% in 2014. This estimate is based on the national reinsurance program parameters and uses pricing assumptions for Aetna's stop loss business adjusted to reflect the anticipated demographics of the 2014 individual market in New York.

The risk corridors program is intended to protect carriers from significant deviation between actual results and carriers' projections, and as such, does not impact the required premium on a prospective basis.

15. Membership Projections

A proprietary projection model was used to evaluate the membership migration under ACA. It was used to form a basis for projecting the membership distribution by metallic level. We consolidated results from the model for several states to produce a common membership distribution that is used on a national basis.

16. Anticipated Loss Ratio

We expect the loss ratio for these products to be 83.28%. This is consistent with the effective retention target of 16.72% of premium. A projection of the MLR for this product is provided on page F-1 of the rate manual. This projection includes anticipated experience for this product for the 12 months in 2014 and does not include a credibility adjustment. We expect this to be equivalent to a Loss Ratio with Federal Adjustments of 89.39%.

17. Area Definitions and Factors

As a result of PPACA, it is anticipated that utilization patterns in the New York Individual market will follow those of the Small Group market going forward. As such, we have used our normalized Small Group experience for the period January 1, 2012 through December 31, 2012 to determine our proposed rating area factors. Our proposed rating area factors are provided on page A-2 of the rate manual.

18. Plan Benefit Factors

We calculate a plan factor to adjust the market base premium rate for differences in plan-specific expected claims. These factors account for differences in benefits, cost sharing, and network design (where applicable). The benchmark Silver plan is assigned a factor of 1.0. The factors were developed using a proprietary pricing model which relies on:

1. State- and product-specific service category weights
2. Rating factors for various levels of cost-sharing options, including deductibles, coinsurance, and, copays

The service category weights are based on experience for our Small Group business. The cost-sharing rating factors are based on experience for our Large Group business which excludes the effects of selection.

Final plan factors reflect the value of the Essential Health Benefits and state mandated benefits (including pediatric dental and vision), the impact of out-of-network benefits, and any additional benefits as indicated in the attached benefit summaries. The final plan factors also consider differences between plans, as applicable, in-network discounts and steerage to preferred providers. No adjustments were made to differentiate benefit factors based on morbidity differences or benefit selection. Final plan factors are displayed on C-1 of the rate manual.

19. Rating Methodology

The premium for each subscriber is calculated as:

Market Base Premium Rate * Area Factor * Plan Factor * Tier Factor

The resulting rate for each subscriber is rounded to the nearest dollar.

As an example of this calculation, consider a family living in Rockland County that enrolls in the New York Aetna Advantage Plus 3000 PD plan. The rate for this family is calculated as:

Market Base Premium Rate	\$610.50
Area Factor	1.000
Plan Factor	0.8594
Single + Spouse + Child(ren)	2.85
Final Rate	\$1,495

The family's final monthly rate is \$1,495.

20. History of Rate Revisions

This is a filing for new products which will be effective beginning January 1, 2014.

21. Company Financial Condition

As of December 31, 2012, the capital and surplus held by Aetna Life Insurance Company was approximately \$3.3 billion. This amount is disclosed in the Company's statutory financial statement dated December 31, 2012. The Company issues insurance nationwide for multiple lines of business including, large group medical, small group medical, individual medical, and various non-medical products.

Certification

I, [REDACTED] 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 the applicable laws and regulations of the State of New York, the requirements under federal law and regulation, the Actuarial Standard of Practice No. 8, "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board, including ASOP 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 also 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]

June 5, 2013

[REDACTED]
Aetna Life Insurance Company

Date

Actuarial Memorandum and Certification In Support of Unified Rate Review Template

General Information

Company Identifying Information:

- Company Legal Name: Aetna Life Insurance Company
- State: New York
- HIOS Issuer ID: 17210
- Market: Individual
- Effective Date: 1/1/2014

Company Contact Information:

- Primary Contact Name: Josephine Williams
- Primary Contact Telephone Number: 860-273-9846
- Primary Contact Email Address: WilliamsJ4@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 Individual New York Minimum Loss Ratio pool in 2012, there is no rebate projected. This is based on the 4/1/2013 reports as well as internal projections showing that the MLR is expected to exceed 80%. Therefore, no expected rebates were adjusted out of the premiums.

Allowed and Incurred Claims Incurred During the Experience Period:

- The 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.
- In order to segregate non-grandfathered experience, we rely on a member-level data set which takes longer to construct than reports at higher levels of aggregation. As such, the experience data used for reporting on premium and incurred claims is paid through February 28, 2013. This data source does not provide detail on utilization levels or claims by service type. We use a different data source to calculate those values; that data is paid through March 31, 2013. The unit cost and utilization detail is considered to be reliable with three months of runoff.

- 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.
- Incurred But Not Paid (IBNP) reserves are estimated using actuarial principles and assumptions that consider 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 IBNP reserves represent 4% of the experience period claims.
- The IBNP completion factor is based on the claims set reported on WS1. This is an appropriate basis for developing the IBNP factors because this basis includes most of the experience reported on WS1 and the claims for members living in New York.

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 April 30, 2013. It includes the impact of:

- Guaranteed Issue (based on a market migration model),
- the Market Level Risk Adjustment,
- the Duration Adjustment (reflecting current durational mix),
- and Individual Uninsured Pent-Up Demand (incorporating first-year impact of previously uninsured participants).

Trend Factors (cost/utilization): The trends utilized for the projections for New York were developed based on Small Group experience for PPO 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 January 2009 – December 2012 paid through December 2012. To develop the pricing trend for 2012, the aggregate net trend for Calendar Year 2012 is normalized for area, seasonality, demographics and plan design. Additional adjustments are made based on items that were believed to have had an effect on the experience data such as changes in provider reimbursements, benefits and an increase in claims due to seasonal flu and snow. The changes in unit price contracted for professional services and the estimated increase in claims expected as a result of seasonal flu and snow were developed by our Medical Economics Unit. The

pricing trend for 2013 and 2014 is developed by applying the value of the expected changes to the above listed items to the 2012 pricing trend.

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 did not rely upon our experience data and have therefore provided manual rating assumptions.

Credibility of Experience

Aetna’s standard for full credibility is 24,000 member months. The New York experience did not exceed 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 63%:

<u>Tier</u>	<u>Projected Membership Distribution</u>	<u>Projected Average Premium</u>	<u>Actuarial Value</u>
Catastrophic	11.4%	\$337	60%
Bronze	67.2%	\$679	60%
Silver	19.3%	\$927	70%
Gold	0.3%	\$908	80%
Platinum	1.7%	\$1058	90%
Total	100.00%	\$695	63%

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):

We are projecting an assessment of \$5.25 per member per month and reinsurance payments of approximately \$39.66 per member per month for a net impact of recovering about \$34.41 per member per month. Projected reinsurance recoveries were based on internal tools used to price stop-loss coverage on large group business, which is reasonably similar to the projected block in that it is guaranteed issue and not medically underwritten. These projections reflect the anticipated demographic mix of 2014 enrollment.

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.

Administrative Expense Load: Projected PMPM costs of \$64.53 for general administrative expenses, which includes 2% for commissions. These projections are derived from corporate experience for individual products and projections of Aetna's individual market enrollment in 2014 and changes in Aetna's cost structure from the 2012 experience.

Profit (or Contribution to Surplus) & Risk Margin: 2% AFIT profit margin

Taxes and Fees: Projected PMPM costs of \$0.08 Risk Adjuster Program Fee and \$0.15 PMPM for Patient Center Outcomes Research Fee, plus 2.6% Health Insurer Fee, 1.08% FIT and 1.75% State Premium Tax. Exchange User Fees were not included in the taxes and fees.

Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is 89.39%, 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 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.

After reviewing the morbidity of our under age 30 enrollment across our book of business, and after considering the impact of the members eligible to enroll in the plan due to hardship, we have priced our catastrophic premiums to be approximately 25% below our bronze premium levels.

AV Metal Values

Information regarding AV Metal Value determination including certifications and calculator snapshots was previously provided in the memorandum included in the rate filing dated April 30, 2013.

AV Pricing Values

The fixed reference plan is 17210NY0050001. 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. There were also no adjustments to the benefit factors for the Child-Only and Dependent Coverage to Age 30.

Membership Projections

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

We developed our projected membership and a distribution of membership by metallic tier based on modeling of market enrollment choices. We have not developed detailed projections of membership by plan or variant. As such, membership was allocated within each metal level on an equal basis to each plan and then to each cost sharing variation within each Silver plan.

The current membership distribution is not meaningful given the magnitude of market changes taking effect on January 1, 2014.

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:

- 17210NY004

Warning Alerts

Total Premium (TP) differs between Worksheets 1 and 2 by \$41, or 0.00004%. 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

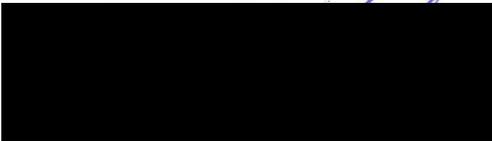
Actuarial certification was previously provided in the rate filing dated April 30, 2013 for the methodology used to calculate the AV Metal Value for each plan.

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.



June 5, 2013

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:	Aetna Life Insurance Company <small>Company submitting the rate adjustment request</small>	HMO - 44 <small>Company Type</small>	For Profit <small>Org. Type</small>	95234 <small>Company NAIC Code</small>
	151 Farmington Avenue, Hartford, CT 06156 <small>Company mailing address</small>			
B. Contact Person:	[REDACTED] Actuarial Manager <small>Rate filing contact person name, title</small>	[REDACTED] <small>Contact phone number</small>	[REDACTED] <small>Contact Email address</small>	
C. Actuarial Contact (If different from above):	[REDACTED] FSA, MAAA, Senior Actuary <small>Actuary name, title</small>	[REDACTED] <small>Actuary phone number</small>	[REDACTED] <small>Actuary Email address</small>	
D. New Rate Information (See Note #1):	January 1, 2014 to December 31, 2014 <small>New rate applicability period</small>	01/01/2014 <small>New rate effective date</small>	AETN-129003886 <small>SERFF Tracking Number</small>	
E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):	Individual			
F. Provide responses for the following questions:	Response			
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	Yes			
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).	Not Applicable			
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.	Not Applicable			

Notes:

- (1) It is recommended that a rate filing application subject to §3231(e)(1) or §4308(c) of the New York Insurance Law be submitted at least 150 days before the proposed effective date. It is recommended that a rate adjustment application not be submitted more than 180 days prior to the proposed effective date. It is recommended that a rate adjustment application not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing.
- (2) A rate adjustment filing submitted pursuant to §3231(e)(1) or §4308(c) of the New York Insurance Law should **not** include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing, a new form or a revision to an existing form, must be a separate filing from the rate adjustment filing.
Use the following SERFF filing types for rate adjustment filings:
 - * For a rate adjustment filing pursuant to §3231(e)(1): Rate Adjustment pursuant to §3231(e)(1)
 - * For a rate adjustment filing pursuant to §4308(c): Rate Adjustment pursuant to §4308(c)
 - * For all other prior approval filings: Normal Pre-Approval
- (3) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment application is submitted to the Insurance Department.

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

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

Company Name: Aetna Life Insurance Company
 NAIC Code: 95234
 SERFF Number: AETN-129003886
 Market Segment: IND

- A. Complete a separate ROW each base medical policy form included in the rate adjustment filing.
 - Information requested applies to New York State business only.
 - Include riders that may be available with that policy form in each policy form response.
 - Insert additional rows as needed to include all base medical policy forms included in a particular rating pool.
 - Add a row with the aggregate values for that entire rating pool and enter an appropriate identifier in column 2. Skip a row between the different rating pools.
- B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG HMO Upstate if rating pools vary by rating region.
- C. In Column 4, market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY SG).
- D. Use the drop down list to enter the market segment.
- E. Product type is HMO, HMO based POS, POS-00N, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans and Base+Supplemental. Indicate appropriate designation for policy form, etc.
- F. The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department). Include a region identifier in this column if needed.
- G. Note that many cells include a drop down list. Use the drop down list for entries.
- H. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
- I. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form										Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)												
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identifier	3. Effective date of rate change (MM/DD/YY)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change	14.1 Beginning Date of the experience period (MM/DD/YY)	14.2 Ending Date of the experience period (MM/DD/YY)	14.3 Member months for experience period	14.4 Earned premiums for experience period (\$)	14.5 Standardized earned premiums for experience period (\$)	14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from payments to the Regulation 146 pool (\$)*	14.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from payments to the Regulation 146 pool (\$)	14.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY (enter receipts from the pool as a negative value) (\$)	14.9 Adjustment to the incurred claims for the period due to receipts from payments to the Regulation 146 pool (enter receipts as a negative value) (\$)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)		
HMO/NY INADVCO-2 7/04	Direct Pay	New York	AHI Individual	01/01/14	IND	HMO	Yes	Closed	1,078	1,274	XX	01/01/12	12/31/12	16,875	21,000,108	23,428,693	22,938,160	24,020,145	(2,737,570)	(5,250,000)	1,751,951	XX
POS/NY INADCO-1 10/00	Direct Pay	New York	AHI Individual	01/01/14	IND	HMO based	Yes	Closed	644	753	XX	01/01/12	12/31/12	9,934	18,205,492	20,329,043	29,684,937	30,178,129	(4,370,164)	(4,632,000)	1,414,604	XX
NY HEALTHYIND-1 09/00 (Ind)	Healthy New	Healthy New	AHI Individual	01/01/14	HNY-IND	HMO	Yes	Closed	1,816	2,417	XX	01/01/12	12/31/12	33,348	12,500,029	15,929,224	19,134,039	20,440,848	(6,009,514)	0	2,873,197	XX
HMO/NY HEALTHYGRCON-1	Healthy New	Healthy New	AHI Sole	01/01/14	HNY-IND	HMO	Yes	Closed	361	639	XX	01/01/12	12/31/12	8,530	2,974,487	3,782,204	3,492,280	3,756,278	(845,580)	0	included in	XX
											XX											XX
											XX											XX
											XX											XX
											XX											XX
											XX											XX

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

1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)												
			15.1 Beginning date of the experience period (MM/DD/YY)	15.2 Ending Date of the experience period (MM/DD/YY)	15.3 Member months for experience period	15.4 Earned premiums for experience period (\$)	15.5 Standardized earned premiums for experience period (\$)	15.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)*	15.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	15.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	16.1 Beginning date of the experience period (MM/DD/YY)	16.2 Ending Date of the experience period (MM/DD/YY)	16.3 Member months for experience period	16.4 Earned premiums for experience period (\$)	16.5 Standardized earned premiums for experience period (\$)	16.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)*	16.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	16.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)			
HMO/NY INDADVCO-2 7/04	Direct Pay	New York	01/01/11	12/31/11	20,085	23,779,498	27,629,484	25,894,343	26,277,458	(3,015,559)	(5,974,469)	3,029,421	XX	01/01/10	12/31/10	24,788	25,545,756	33,643,153	29,642,108	29,966,881	(2,980,504)	(5,550,180)	1,409,926	XX	
POS/NY INADCO-1 10/00	Direct Pay	New York	01/01/11	12/31/11	11,943	21,044,797	24,446,599	29,969,242	30,029,917	(4,261,585)	(5,687,284)	3,257,758	XX	01/01/10	12/31/10	15,811	24,398,641	32,241,418	28,448,659	28,695,174	(4,883,641)	(4,128,378)	1,106,630	XX	
NY HEALTHYIND-1 09/00 (Ind)	Healthy New	Healthy New	01/01/11	12/31/11	39,533	13,219,365	19,082,708	25,230,446	25,782,919	(6,494,299)	0	4,112,833	XX	01/01/10	12/31/10	45,310	13,585,125	21,751,764	22,822,823	22,732,527	(7,438,049)	0	2,350,963	XX	
HMO/NY HEALTHYGRCON-1	Healthy New	Healthy New	01/01/11	12/31/11	9,436	2,889,039	4,179,103	3,556,927	3,792,833	(861,699)	0	included in	XX	01/01/10	12/31/10	10,198	3,047,784	4,890,957	3,203,986	3,417,317	(1,136,084)	0	included in	XX	
													XX											XX	
													XX												XX
													XX												XX
													XX												XX
													XX												XX

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Aetna Life Insurance Company
 NAIC Code: 95234
 SERFF Number: AETN-129003886
 Market Segment: IND

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

General

Product*	ElectChoiceOpenAcce	ElectChoiceOpenAcce	ElectChoiceOpenAcce	ElectChoiceOpenAcce	ElectChoiceOpenAcce	ManagedChoiceOpen
Product ID*						17210NY005
Metal Level (or catastrophic)*						Platinum
AV Metal Value (HHS Calculator)*						0.881
AV Pricing Value (total, risk pool experience based)*						1.3538
Plan Type*						MC
Plan Name*						NY Aetna Pinnacle PD
Plan ID*						17210NY0050006
Exchange Plan?*						No

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

Experience Period Index Rate

Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period	123,842,354		
Member-Months for Latest Experience Period	348,588		
Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	355.27		
Average Pricing Actuarial Value reflected in experience period	0.784		
AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	453.12		453.12

Market Wide Adjustments to the AV Adjusted Experience Period Index Rate

Impact of adjusting experience period data to EHB benefit level	1.0244
Market wide adjustment for changes in provider network **	0.9422
Market wide adjustment for fee schedule changes **	1.0000
Market wide adjustment for utilization management changes **	1.0000
Impact on risk pool of changes in expected covered membership risk characteristics **	0.8878
Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]	1.1970
Adjustment for changes in distribution of risk pool membership by rating regions **	1.0000
Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery)	1
Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.9406
Impact of adjustments due to experience period claim data not being sufficiently credible	1.0000

Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.2853		
Other 1 (Adjustment to Silver Plan level plus Pediatric Dental)	0.7144		
Other 2 (Tier ratio adjustment)	1.2397		
Other 3 (Rating Area Normalization)	1.0217		
Impact of Market Wide Adjustments (product L13 through L26)	1.1220		1.122
** Not Included in Claim Trend Adjustment			
Plan Level Adjustments			
Pricing actuarial value (without induced demand factor) #	1.000		1.222
Pricing actuarial value (only the induced demand factor) #	1.000		1.108
Impact of provider network characteristics ##	1.000		1.000
Impact of delivery system characteristics ##	1.000		1.000
Impact of utilization management practices ##	1.000		1.000
Benefits in additional to EHB (greater than 1.00)	1.000		1.000
Administrative costs (excluding Exchange user fees and profits)	1.177		1.177
Profit/Contribution to surplus margins	1.020		1.020
Impact of eligibility categories (catastrophic plans only)	1.000		1.000
Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000		1.000
Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000		1.000
Other 1 (specify)	1.000		1.000
Other 2 (specify)	1.000		1.000
Impact of Plan Level Adjustments (product L28 through L40)	1.201		1.626
# 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			
TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)	610.50		826.49

EXHIBIT 9: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES INCLUDED IN CURRENT FILING

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

Company Name: Aetna Life Insurance Company
 NAIC Code: 95234
 SERFF Number: AETN-129003886
 Market Segment: IND

- A. Complete a separate ROW for Metal Level/Exchange product in the current new On/Off Exchange product filing.
 • Information should be for all the benefits included in that plan design (medical, drugs, etc).
 • Enter the Metal Tier the On/Off Exchange product belongs to using the drop down menu, or enter a value.
 • Enter the On/Off Designation using the drop down menu.
 • Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.
- B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).
- C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.
- D. This form must be submitted as an Excel file and as a PDF file.

1. Metal Level (drop down menu)	2. On/Off Exchange Designation (drop down menu)	3. Exchange Product Name	4.1 Period assumed - beginning date (MM/DD/YY)	4.2 Period assumed - ending date (MM/DD/YY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10
Platinum	Off Exchange		01/01/14	12/31/14	11.80%	0.20%	0.60%	3.00%	1.75%	6.39%	3.97%	15.91%	3.00%	0.01%	0.23%	1.62%	35.00%	0.00%	20.54%
Gold	Off Exchange		01/01/14	12/31/14	11.80%	0.20%	0.60%	3.00%	1.75%	6.39%	3.97%	15.91%	3.00%	0.01%	0.23%	1.62%	35.00%	0.00%	20.54%
Silver	Off Exchange		01/01/14	12/31/14	11.80%	0.20%	0.60%	3.00%	1.75%	6.39%	3.97%	15.91%	3.00%	0.01%	0.23%	1.62%	35.00%	0.00%	20.54%
Bronze	Off Exchange		01/01/14	12/31/14	11.80%	0.20%	0.60%	3.00%	1.75%	6.39%	3.97%	15.91%	3.00%	0.01%	0.23%	1.62%	35.00%	0.00%	20.54%

EXHIBIT 9: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES INCLUDED IN CURRENT FILING

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	12.3 Commissions and broker fees - as \$mpm	12.4 Premium Taxes - as \$mpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm	12.6 Other administrative expenses - as \$mpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as \$mpm	14. State income tax component - as \$mpm	15. Federal income tax component - as \$mpm	16. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Platinum	On Exchange - Std	NY Aetna Pinnacle	1.39	4.17	20.85	12.16 44.41 27.59			110.56	20.85	0.05	11.26	0.00	
						2.16 44.41								
						2.16 44.41								
						2.16 44.41								
		DAEPO				2.16 44.41								
Platinum	Off Exchange		1.39	4.17	20.85	12.16 44.41 27.59			110.56	20.85	0.05	11.26	0.00	142.72
Gold	Off Exchange		1.39	4.17	20.85	12.16 44.41 27.59			110.56	20.85	0.05	11.26	0.00	142.72
Silver	Off Exchange		1.39	4.17	20.85	12.16 44.41 27.59			110.56	20.85	0.05	11.26	0.00	142.72
Bronze	Off Exchange		1.39	4.17	20.85	12.16 44.41 27.59			110.56	20.85	0.05	11.26	0.00	142.72

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 Life Insurance Company										State:	NY																							
4	HIOS Issuer ID:	17210										Market:	Individual																							
5	Effective Date of Rate Change(s):	1/1/2014																																		
6																																				
7																																				
8	Market Level Calculations (Same for all Plans)																																			
9																																				
10																																				
11	Section I: Experience period data																																			
12	Experience Period:	1/1/2012		to	12/31/2012																															
13		<u>Experience Period</u>																																		
14	Premiums (net of MLR Rebate) in Experience Period:	<u>Aggregate Amount</u>	<u>PMPM</u>	<u>% of Prem</u>																																
15		1,092,151	\$130.80	100.00%																																
16	Incurred Claims in Experience Period	2,774,950	332.33	254.08%																																
17	Allowed Claims:	\$3,198,896	383.10	292.90%																																
18	Index Rate of Experience Period	\$382.38																																		
19	Experience Period Member Months	8,350																																		
20	Section II: Allowed Claims, PMPM basis																																			
21		<u>Experience Period</u>				<u>Projection Period:</u>		1/1/2014		to	12/31/2014		<u>Mid-point to Mid-point, Experience to Projection:</u>				24				<u>months</u>															
22		<u>on Actual Experience Allowed</u>				<u>Adj't. from Experience to 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	407.61	1,579.36	\$53.65	1.197	1.855	1.042	1.073		562.14	\$3,178.59	\$148.90	393.64	6904.47	\$226.49																				
25	Outpatient Hospital	Visits	329.53	1,080.68	29.68	1.197	1.855	1.042	1.073		454.46	2,174.97	82.37	571.73	2357.43	112.32																				
26	Professional	Visits	5,071.55	185.32	78.32	1.197	1.855	1.042	1.073		6,994.28	372.98	217.39	10075.91	314.37	263.96																				
27	Other Medical	Visits	5,815.93	307.84	149.20	1.197	1.855	1.042	1.073		8,020.87	619.55	414.11	7881.49	346.02	227.26																				
28	Capitation	Benefit Period	0.00	0.00	0.00	1.197	1.855	1.042	1.073		0.00	0.00	0.00	1.00	1.00	0.00																				
29	Prescription Drug	Prescriptions	6,198.19	139.90	72.26	1.197	1.855	1.042	1.073		8,548.04	281.55	200.56	13945.32	200.76	233.31																				
30	Total				\$383.10								\$1,063.33			\$1,063.33																				
31																	<u>After Credibility</u>	<u>Projected Period Totals</u>																		
32	Section III: Projected Experience:																																			
33	Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)																	100.00%																		
34	Paid to Allowed Average Factor in Projection Period																																			
35	Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM																																			
36	Projected Risk Adjustments PMPM																																			
37	Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM																																			
38	Projected ACA reinsurance recoveries, net of rein prem, PMPM																																			
39	Projected Incurred Claims																																			
40	Administrative Expense Load																																			
41	Profit & Risk Load																																			
42	Taxes & Fees																																			
43	Single Risk Pool Gross Premium Avg. Rate, PMPM																																			
44	Index Rate for Projection Period																																			
45	% increase over Experience Period																																			
46	% Increase, annualized:																																			
47	Projected Member Months																																			
48																																				
49	Information Not Releasable to the Public Unless Authorized by Law: This information has not been publicly 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.																																			
50																																				

Product-Plan Data Collection

Company Legal Name:
 HIOS Issuer ID:
 Effective Date of Rate Change(s):

Aetna Life Insurance Company
17210
1/1/2014

State: **NY**
 Market: **Individual**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	Terminated Product	Elect Choice Open Access												Aetna PPO		
Product ID:	17210NY004	17210NY005												17210NY006		
Metal:	Catastrophic	Silver	Gold	Platinum	Bronze	Catastrophic	Silver	Silver	Bronze	Bronze	Platinum	Platinum	Gold	Gold	Platinum	
AV Metal Value	0.000	[REDACTED]														0.881
AV Pricing Value	0.001	[REDACTED]														1.354
Plan Type:	EPO	[REDACTED]														PPO
Plan Name	Terminated Product	[REDACTED]														
Plan ID (Standard Component ID):	17210NY0040000	17210NY005												Aetna Pinnacle PD		
Exchange Plan?	No	[REDACTED]														17210NY0060000
Historical Rate Increase - Calendar Year - 2	0.00%	[REDACTED]														No
Historical Rate Increase - Calendar Year - 1	0.00%	[REDACTED]														0.00%
Historical Rate Increase - Calendar Year 0	0.00%	[REDACTED]														0.00%
Effective Date of Proposed Rates	1/1/2014	[REDACTED]														1/1/2014
Rate Change % (over prior filing)	0.00%	[REDACTED]														0.00%
Cum'tive Rate Change % (over 12 mos prior)	0.00%	[REDACTED]														-999.00%
Proj'd Per Rate Change % (over Exper. Period)	0.00%	[REDACTED]														#DIV/0!
Product Threshold Rate Increase %	#DIV/0!	[REDACTED]														0.00%

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

Plan ID (Standard Component ID):	Total	17210NY0040000	[REDACTED]												17210NY0060000		
Inpatient	\$0.00	\$0.00	[REDACTED]														\$0.00
Outpatient	\$0.00	\$0.00	[REDACTED]														\$0.00
Professional	\$0.00	\$0.00	[REDACTED]														\$0.00
Prescription Drug	\$0.00	\$0.00	[REDACTED]														\$0.00
Other	\$0.00	\$0.00	[REDACTED]														\$0.00
Capitation	\$0.00	\$0.00	[REDACTED]														\$0.00
Administration	\$0.00	\$0.00	[REDACTED]														\$0.00
Taxes & Fees	\$0.00	\$0.00	[REDACTED]														\$0.00
Risk & Profit Charge	\$0.00	\$0.00	[REDACTED]														\$0.00
Total Rate Increase	\$0.00	\$0.00	[REDACTED]														\$0.00
Member Cost Share Increase	\$0.00	\$0.00	[REDACTED]														\$0.00
Average Current Rate PMPM	\$754.69	\$130.80	[REDACTED]														\$1,058.06
Projected Member Months	141,000	0	[REDACTED]														4,500

Section III: Experience Period Information

Plan ID (Standard Component ID):	Total	17210NY0040000	[REDACTED]												17210NY0060000			
Average Rate PMPM	\$130.80	\$130.80	[REDACTED]															
Member Months	8,350	8,350	[REDACTED]															
Total Premium (TP)	\$1,092,151	\$1,092,151	[REDACTED]														\$0	
Premium Information	EHB basis or full portion of TP, [see instructions]	0.00%	[REDACTED]															
	state mandated benefits portion of TP that are other than EHB	0.00%	[REDACTED]															
	Other benefits portion of TP	100.00%	[REDACTED]														100.00%	
	Total Allowed Claims (TAC)	\$3,198,896	\$3,198,896	[REDACTED]														
Claims Information	EHB basis or full portion of TAC, [see instructions]	99.81%	[REDACTED]															
	state mandated benefits portion of TAC that are other than EHB	0.00%	[REDACTED]															
	Other benefits portion of TAC	0.19%	[REDACTED]														100.00%	
	Allowed Claims which are not the issuer's obligation:	\$423,946	\$423,946	[REDACTED]														
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0		[REDACTED]														
	Portion of above payable by HHS on behalf of insured person, as %	0.00%		[REDACTED]														
Total Incurred claims, payable with issuer funds	\$2,774,950	\$2,774,950	[REDACTED]														\$0	
Net Amt of Rein	\$0.00	\$0.00	[REDACTED]															

Net Amt of Risk Adj	\$0.00	\$0.00		
Incurring Claims PMPM	\$332.33	\$332.33		#DIV/0!
Allowed Claims PMPM	\$383.10	\$383.10		#DIV/0!
EHB portion of Allowed Claims, PMPM	\$382.38	\$382.38		#DIV/0!

Section IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	17210NY0040000	1	17210NY0060000
Average Rate PMPM	\$754.69	\$130.80		\$1,058.06
Member Months	141,000	-		4,500
Total Premium (TP)	\$106,411,435	\$0		\$4,761,253
Premium Information				
EHB basis or full portion of TP, [see instructions]	99.90%			99.90%
state mandated benefits portion of TP that are other than EHB	0.00%			0.00%
Other benefits portion of TP	0.10%	100.00%		0.10%
Total Allowed Claims (TAC)	\$149,930,155			\$4,832,855
Claims Information				
EHB basis or full portion of TAC, [see instructions]	99.90%			99.90%
state mandated benefits portion of TAC that are other than EHB	0.00%			0.00%
Other benefits portion of TAC	0.10%	100.00%		0.10%
Allowed Claims which are not the issuer's obligation	\$60,565,756			\$575,110
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0			
insured person, as %	0.00%			
Total Incurred claims, payable with issuer funds	\$89,364,399	\$0		\$4,257,745
Net Amt of Rein	\$4,851,710			\$154,842
Net Amt of Risk Adj	\$0			\$0
Incurring Claims PMPM	\$633.79	#DIV/0!		\$946.17
Allowed Claims PMPM	\$1,063.33	#DIV/0!		\$1,073.97
EHB portion of Allowed Claims, PMPM	\$1,062.30	#DIV/0!		\$1,072.92

Aetna Life Insurance Company

**Policy Forms: HIXGR-96801, HIXGR-96809, OffHIXGR-96807,
OffHIXGR-96804, OffHIXGR-96810, OffHIXGR-96811
HIOS Product ID: 17210NY005
SERFF Tracking Number: AETN-129003886**

**Exhibit A-1
New York Individual Market Base Premium Rate Development**

		Individual PPO	Small Group PPO
1) Member Months (Oct 11-Sep 12)		348,588	348,588
2) Paid Claims PMPM (Oct 11-Sep 12)		\$355.43	\$355.43
a) Age 27 to 29 Dependent PMPM		\$0.16	\$0.16
Adjusted Paid Claims PMPM (Oct 11-Sep 12)		\$355.27	\$355.27
3) Normalize:			
a) Weighted Average Benefit Factor	/	0.7840	0.7840
b) Benefit Index for Silver Plan	x	0.7144	0.7144
c) Rating Area Factor Normalization	/	0.9787	0.9787
d) EHB Adjustment	x	1.0244	1.0244
4) Normalized PMPM Claims Subtotal	=	\$338.83	\$338.83
5) Tier Ratio Adjustment	x	1.2109	1.2109
6) Market Level Risk Adjustment	x	0.8878	0.8878
7) Comparative HCR Claims per Segment	=	\$364.26	\$364.26
8) Post-ACA Morbidity Ratio	x	1.1970	
9) Allowed Claim Trend - Rate		11.80%	
No. of Months		27	
10) Claim Trend Factor	x	1.2853	
11) Network Recontracting Adjustment	x	0.9422	
12) Silver Medical Base Claim Rate	=	\$528.01	
13) Pediatric Dental	+	\$12.53	
14) Silver Final Base Claim Rate	=	\$540.54	
15) Market-Level Reinsurance	x	0.9406	
16) Expected Net Claims	=	\$508.42	
17) 1 - Retention	/	83.28%	
18) Base Premium before Reinsurance and Risk Adjustment	=	\$610.50	
19) Market-level Risk Adjustment	x	1.0000	
20) Silver Base Premium Rate	=	\$610.50	

Aetna Life Insurance Company

**Policy Forms: HIXGR-96801, HIXGR-96809, OffHIXGR-96807,
OffHIXGR-96804, OffHIXGR-96810, OffHIXGR-96811
SERFF Tracking Number: AETN-129003886**

Exhibit A-2 New York Individual Market Base Premium Rate Development

This exhibit summarizes the adjustments made to historical experience in developing the market base premium rate illustrated in Exhibit A-1. We include small group experience and adjustments through Line 7 to demonstrate the relationship between normalized claims for our current individual and small group business in New York after accounting for the impact of adopting guaranteed issue and modified community rating. This comparison is intended as a reasonability check on both the historical individual claims experience and the associated adjustments. We note that the small group experience is based on a larger population and is more similar to the anticipated 2014 Individual market.

- Lines 1 and 2
 - 1 - Member months for experience incurred 10/1/2011 through 09/31/2012 and paid through 12/31/2012
 - 2 - Corresponding paid claims PMPM based on the Small Group PPO claims experience.
 - Approximately 2.1% of the individual claims on Line 2 are a provision for claims incurred but not reported (IBNR) as of 12/31/2012.
 - No credibility adjustment is made to experience period claims since the New York experience for each market exceeds Aetna's threshold for full credibility which is set at 24,000 member months.
- Lines 3a through 3c are used to normalize claims to a common basis. Adjustments include:
 - 3a and 3b – Adjustment to reflect the difference between the current mix of benefit plans and the benefit level for a common silver plan
 - 3c – Adjustment to normalize changes in the proposed rating area factors effective 01/01/2014
 - 3d – Adjustment to include costs for state-specific Essential Health Benefits (EHBs) not included in Aetna's existing benefit factors
- Line 4
 - Product of Lines 2, 3b, and 3c, divided by Lines 3a
- Line 5
 - Adjustment to normalize the current Small Group tier relativities to the 2014 tier relativities specified by the New York Department of Financial Services
- Line 6
 - Adjustment to reflect differences between the morbidity-profile of Aetna's historical experience and the overall neutral market. This adjustment brings the underlying experience to the overall market level.
- Line 7
 - Product of Lines 4 – 6
- Line 8
 - Ratio of Post-ACA Individual morbidity to Post-ACA Small Group Morbidity
- Lines 9 and 10
 - Medical trend factor used to project historical experience to the pricing period. Please see Exhibit B for support of the trend assumption.

- Line 11
 - Adjustment for changes in network contracts between the historical experience and products/network that will be offered in 2014.
- Line 12
 - Product of Lines 7, 8, 10, and 11
- Line 13
 - Estimated cost of pediatric dental claims adjusted to the basis for the base premium rate
- Line 14
 - Sum of Lines 12 and 13
- Line 15
 - Anticipated reduction in claims costs due to expected reimbursements from the federal reinsurance program
- Line 16
 - Product of Lines 14 and 15
- Line 17
 - One minus the estimated portion of premium required for retention. Please see Section 12 of the Actuarial Memorandum for a discussion of our retention assumptions.
- Line 18
 - Line 16 divided by Line 17
- Line 19
 - Adjustment for the anticipated impact of the federal risk adjustment program
- Line 20
 - Final Base Premium Rate for the Standard Silver Plan, calculated as a product of Lines 18 and 19

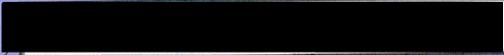
Exhibit B
Trend Analysis
Small Group HMO Experience

Month/Year Incurred	Membership	Normalized Medical Claims PMPM				Annualized Medical Trend			
		1-Month	3-Month Rolling	6-Month Rolling	12-Month Rolling	1-Month Rolling	3-Month Rolling	6-Month Rolling	12-Month Rolling
Jan-10	50,220	\$261.98							
Feb-10	48,147	\$278.91							
Mar-10	45,500	\$305.85	\$281.52						
Apr-10	43,326	\$298.99	\$294.21						
May-10	40,907	\$290.24	\$298.64						
Jun-10	37,749	\$329.05	\$305.36	\$292.46					
Jul-10	36,041	\$296.69	\$305.04	\$299.15					
Aug-10	34,582	\$304.24	\$310.37	\$303.98					
Sep-10	32,452	\$281.29	\$294.37	\$300.33					
Oct-10	31,492	\$314.26	\$299.88	\$302.66					
Nov-10	30,447	\$306.26	\$300.34	\$305.70					
Dec-10	29,107	\$279.01	\$300.32	\$297.16	\$294.44				
Jan-11	28,552	\$327.83	\$304.25	\$301.94	\$300.34	25.1%			
Feb-11	28,343	\$292.11	\$299.53	\$299.96	\$302.25	4.7%			
Mar-11	27,961	\$323.50	\$314.47	\$307.14	\$303.32	5.8%	11.7%		
Apr-11	27,784	\$314.96	\$310.10	\$307.10	\$304.64	5.3%	5.4%		
May-11	27,640	\$343.61	\$327.32	\$313.21	\$309.12	18.4%	9.6%		
Jun-11	27,279	\$321.00	\$326.53	\$320.42	\$307.94	-2.4%	6.9%	9.6%	
Jul-11	27,115	\$304.85	\$323.28	\$316.61	\$308.85	2.7%	6.0%	5.8%	
Aug-11	26,987	\$341.25	\$322.33	\$324.86	\$311.84	12.2%	3.9%	6.9%	
Sep-11	27,175	\$313.85	\$319.94	\$323.26	\$314.92	11.6%	8.7%	7.6%	
Oct-11	27,153	\$338.35	\$331.12	\$327.18	\$316.88	7.7%	10.4%	8.1%	
Nov-11	27,254	\$369.17	\$340.48	\$331.42	\$322.14	20.5%	13.4%	8.4%	
Dec-11	27,815	\$334.52	\$347.27	\$333.69	\$326.97	19.9%	15.6%	12.3%	11.0%
Jan-12	28,840	\$364.46	\$356.07	\$343.79	\$330.16	11.2%	17.0%	13.9%	9.9%
Feb-12	29,157	\$401.41	\$367.31	\$354.24	\$339.66	37.4%	22.6%	18.1%	12.4%
Mar-12	29,269	\$346.19	\$370.68	\$359.32	\$341.59	7.0%	17.9%	17.0%	12.6%
Apr-12	29,543	\$345.54	\$364.27	\$360.27	\$344.15	9.7%	17.5%	17.3%	13.0%
May-12	29,584	\$366.01	\$352.60	\$359.85	\$346.11	6.5%	7.7%	14.9%	12.0%
Jun-12	29,756	\$339.94	\$350.48	\$360.48	\$347.58	5.9%	7.3%	12.5%	12.9%
Jul-12	29,842	\$367.77	\$357.90	\$361.07	\$352.73	20.6%	10.7%	14.0%	14.2%
Aug-12	30,042	\$357.84	\$355.21	\$353.92	\$354.07	4.9%	10.2%	8.9%	13.5%
Sep-12	30,333	\$328.01	\$351.10	\$350.79	\$354.94	4.5%	9.7%	8.5%	12.7%
Oct-12	30,746	\$345.06	\$343.60	\$350.67	\$355.36	2.0%	3.8%	7.2%	12.1%
Nov-12	31,036	\$346.92	\$340.07	\$347.54	\$353.56	-6.0%	-0.1%	4.9%	9.8%
Dec-12	31,719	\$381.26	\$357.96	\$354.59	\$357.47	14.0%	3.1%	6.3%	9.3%

Average Last 6 with 3 month lag: **13.0%**

Trend Pick: **11.8%**

**Accident and Health Insurance Initial Premium Rates
Compliance Certification**

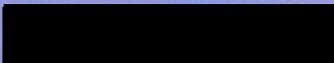
I, , a duly authorized officer of  Aetna Life Insurance Company, the insurer, do hereby certify that I am knowledgeable as to the laws, regulations and circular letters applicable to the type of insurance coverage and premium rates submitted, and that such rates, actuarial memorandum, supporting rate materials and rate manual pages are in compliance with the applicable laws, regulations and circular letters to the best of my knowledge and belief. I further hereby certify that the information relating to rates set forth in this filing is true to the best of my knowledge and belief. I understand that the Department of Financial Services will rely on this certification, and should it be determined that this certification is materially false or incorrect, appropriate corrective and disciplinary action, as authorized by law, will be taken by the Department of Financial Services against the company and the officer completing this certification.



04/30/2013

Signature of Authorized Officer

Date



151 Farmington Avenue

Print Name of Authorized Officer

Address of Insurer, Article 43
Corporation or HMO

Senior Actuary

Hartford, CT 06156

Title

City, State, Zip Code





Direct Telephone Number

E-Mail Address



Fax Number

Reset Form