Filing at a Glance

Company:	Aetna Life Insurance Company
Product Name:	NY SG ALIC 1Q14-4Q14
State:	New York
TOI:	H15G Group Health - Hospital/Surgical/Medical Expense
Sub-TOI:	H15G.003 Small Group Only
Filing Type:	Off Exchange NG Forms & Rates
Date Submitted:	05/15/2013
SERFF Tr Num:	AETN-128993202
SERFF Status:	Pending State Action
State Tr Num:	2013050116
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	[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: *H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*
Product Name: *NY SG ALIC 1Q14-4Q14*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 05/20/2013
State Status Changed:
Created By: [redacted]
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: [redacted]

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:
New York 1q14-4q14 Small Group filing.

Company and Contact

Filing Contact Information

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Blue Bell, PA 19422

Filing Company Information

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
[redacted] ext. [Phone]

CoCode: 60054
Group Code: 1
Group Name:
FEIN Number: 06-6033492

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

State: *New York* **Filing Company:** *Aetna Life Insurance Company*
TOI/Sub-TOI: *H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*
Product Name: *NY SG ALIC 1Q14-4Q14*
Project Name/Number: */*

1. Is a parallel product being submitted for another entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): Yes. AHI - AETN-128992632, AHIC - AETN-129024449
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Commercial
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): Blanket
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Rate and Form
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: No
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): No

Section XIV.
Bronze OAEPO 3500 50% SCHEDULE OF BENEFITS
Bronze

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $3,500 $7,000	
Out-of-Pocket Limit • Individual • Family	 $5,800 $11,600	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	50% Coinsurance after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	50% Coinsurance after Deductible	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	

• Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	50% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	50% Coinsurance after Deductible	See Benefit For Description
Emergency Department	50% Coinsurance after Deductible	See Benefit For Description
Urgent Care Center	50% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	50% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	50% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	50% Coinsurance after	See Benefits For Description

Preauthorization Required	Deductible	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	50% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services	50% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance after Deductible	60 visits per Plan Year combined therapies
Home Health Care	25% Coinsurance	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services • Home Infusion Therapy	50% Coinsurance after Deductible 50% Coinsurance after Deductible	
Inpatient Medical Visits	50% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery	Covered In Full 50% Coinsurance per admission after Deductible 50% Coinsurance per admission after Deductible	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early

• Breast Pump **Preauthorization Required**	Covered in Full	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	50% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	50% Coinsurance after Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance after Deductible	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	50% Coinsurance after Deductible	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	50% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	50% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description See Prescription Drug Benefit

Durable Medical Equipment & Braces	50% Coinsurance after Deductible	See Benefit For Description
External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 50% Coinsurance per admission after Deductible 50% Coinsurance after Deductible	 5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	50% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	50% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility	50% Coinsurance	200 Days Per Plan Year

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

Tier 3	50% up to $750 after Deductible	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment after Deductible $100 Copayment after Deductible 50% Coinsurance up to $1,500 after Deductible	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 50% Coinsurance after Deductible 0% Coinsurance 0% Coinsurance	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
Bronze OAEPO 3500 60% HSA PY SCHEDULE OF BENEFITS
Bronze

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $3,500 $7,000	
Out-of-Pocket Limit • Individual • Family	 $6,250 $12,500	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	40% Coinsurance after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	40% Coinsurance after Deductible	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
• Routine Gynecological	Covered in full	

Services/Well Woman Exams*		
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	40% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	40% Coinsurance after Deductible	See Benefit For Description
Emergency Department	40% Coinsurance after Deductible	See Benefit For Description
Urgent Care Center	40% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	40% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	40% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	40% Coinsurance after Deductible	See Benefits For Description

Preauthorization Required		
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	40% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after	See Benefit For Description

Outpatient Hospital Services	Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	40% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance after Deductible	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after	See Benefit For Description

Outpatient Hospital Services • Home Infusion Therapy	Deductible 40% Coinsurance after Deductible	
Inpatient Medical Visits	40% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered In Full 40% Coinsurance per admission after Deductible 40% Coinsurance per admission after Deductible Covered in Full	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast

Preauthorization Required		feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	40% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	40% Coinsurance after Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	40% Coinsurance after Deductible	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	40% Coinsurance after Deductible	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	40% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	40% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment &	50% Coinsurance after	See Benefit For Description

Braces	Deductible	
External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 40% Coinsurance per admission after Deductible 40% Coinsurance after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	40% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	40% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac &	40% Coinsurance per admission after	200 Days Per Plan Year

Pulmonary Rehabilitation) **Preauthorization Required**	Deductible	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	40% Coinsurance per admission after Deductible	60 Days Per Plan year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	40% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	40% Coinsurance after Deductible	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	40% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	40% Coinsurance after Deductible	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment after Deductible $50 Copayment after Deductible 50% Coinsurance up to	See Benefit For Description

	$750 after Deductible	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment after Deductible $100 Copayment after Deductible 50% Coinsurance up to $1,500 after Deductible	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 40% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
Bronze OAEPO 4000 80% SCHEDULE OF BENEFITS
Bronze

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $4,000 $8,000	
Out-of-Pocket Limit • Individual • Family	 $6,000 $12,000	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$25 Copayment after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	20% Coinsurance after Deductible	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
• Routine Gynecological	Covered in full	

Services/Well Woman Exams*		
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	20% Coinsurance after Deductible	See Benefit For Description
Emergency Department	20% Coinsurance after Deductible	See Benefit For Description
Urgent Care Center	20% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	20% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	20% Coinsurance after Deductible	See Benefits For Description

Preauthorization Required		
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$25 Copayment after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	20% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as	$25 Copayment after Deductible 20% Coinsurance after Deductible 20% Coinsurance	See Benefit For Description

Outpatient Hospital Services	after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance	See Benefit For Description

Outpatient Hospital Services • Home Infusion Therapy	after Deductible 20% Coinsurance after Deductible	
Inpatient Medical Visits	20% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$20 Copayment after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered In Full 20% Coinsurance per admission after Deductible 20% Coinsurance per admission after Deductible Covered in Full	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding

Preauthorization Required		
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	20% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	20% Coinsurance After Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	$25 Copayment after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	20% Coinsurance after Deductible	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	20% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	20% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	$25 Copayment after Deductible $25 Copayment after Deductible	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment & Braces	50% Coinsurance after Deductible	See Benefit For Description

External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 20% Coinsurance per admission after Deductible 20% Coinsurance after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	20% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	20% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	20% Coinsurance per admission after Deductible	200 Days Per Plan Year

Preauthorization Required		
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	20% Coinsurance per admission after Deductible	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	20% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	20% Coinsurance after Deductible	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	20% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	20% Coinsurance after Deductible	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment after Deductible $50 Copayment after Deductible 50% Coinsurance up to $750 after Deductible	See Benefit For Description

Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment after Deductible $100 Copayment after Deductible 50% Coinsurance up to $1,500 after Deductible	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 20% Coinsurance after Deductible 0% Coinsurance 0% Coinsurance	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
Bronze OAEPO 5000 60% SCHEDULE OF BENEFITS
Bronze

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $5,000 $10,000	
Out-of-Pocket Limit • Individual • Family	 $6,250 $12,500	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$50 Copayment	See Benefit For Description
Specialist Office Visits (or Home Visits)	40% Coinsurance after Deductible	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	

• Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	40% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	40% Coinsurance after Deductible	See Benefit For Description
Emergency Department	40% Coinsurance after Deductible	See Benefit For Description
Urgent Care Center	40% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	40% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	40% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	40% Coinsurance after	See Benefits For Description

Preauthorization Required	Deductible	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	40% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	$50 Copayment 40% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services	40% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	40% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services • Home Infusion Therapy	40% Coinsurance after Deductible 40% Coinsurance after Deductible	
Inpatient Medical Visits	40% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$50 Copayment 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery	Covered In Full 40% Coinsurance per admission after Deductible 40% Coinsurance per admission after Deductible	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early

• Breast Pump **Preauthorization Required**	Covered in Full	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	40% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	40% Coinsurance after Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $50 Copayment 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	40% Coinsurance after Deductible	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	40% Coinsurance after Deductible	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	40% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	40% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	$50 Copayment $50 Copayment	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment &	50% Coinsurance after	See Benefit For Description

Braces	Deductible	
External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 40% Coinsurance per admission after Deductible 40% Coinsurance after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	40% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	40% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac &	40% Coinsurance per admission after	200 Days Per Plan Year

Pulmonary Rehabilitation) **Preauthorization Required**	Deductible	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	40% Coinsurance per admission after Deductible	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	40% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	40% Coinsurance	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	40% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	40% Coinsurance	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2	 $10 Copayment after Deductible 50% Coinsurance after Deductible (Can be obtained only with medical exception.)	See Benefit For Description

Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2	 $20 Copayment after Deductible 50% Coinsurance after Deductible (Can be obtained only with medical exception.)	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 40% Coinsurance after Deductible 0% Coinsurance 0% Coinsurance	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
Bronze OAEPO 2500 100% HSA PY SCHEDULE OF BENEFITS
Bronze

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $2,500 $5,000	
Out-of-Pocket Limit • Individual • Family	 $6,250 $12,500	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$50 Copayment after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	$75 Copayment after Deductible	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
• Routine Gynecological	Covered in full	

Services/Well Woman Exams*		
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	0% Coinsurance after Deductible	See Benefit For Description
Emergency Department Copayment waived if Hospital admission.	$200 Copayment after Deductible	See Benefit For Description
Urgent Care Center	$75 Copayment after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	$75 Copayment after Deductible $75 Copayment after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	$500 Copayment after Deductible	See Benefit For Description
Anesthesia Services (all settings)	0% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	0% Coinsurance after	See Benefits For Description

Preauthorization Required	Deductible	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$75 Copayment after deductible $75 Copayment after Deductible $75 Copayment after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$75 Copayment after Deductible $75 Copayment after Deductible $75 Copayment after Deductible	See Benefit For Description
Chiropractic Services	$75 Copayment after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	$50 Copayment after Deductible $75 Copayment after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services	$75 Copayment after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	$75 Copayment after Deductible $75 Copayment after Deductible $75 Copayment after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$75 Copayment after Deductible	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance after Deductible	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	$75 Copayment after Deductible $75 Copayment after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services • Home Infusion Therapy	$75 Copayment after Deductible $75 Copayment after Deductible	
Inpatient Medical Visits	0% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$75 Copayment after Deductible $75 Copayment after Deductible $75 Copayment after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered In Full $1,000 Copayment per admission after Deductible 0% Coinsurance per admission after Deductible Covered in Full	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast

Preauthorization Required		feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	$500 Copayment after Deductible	See Benefit For Description
Preadmission Testing	$75 Copayment after Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $75 Copayment after Deductible $75 Copayment after Deductible $75 Copayment after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $75 Copayment after Deductible $75 Copayment after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$75 Copayment after Deductible	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$75 Copayment after Deductible	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	$1,000 Copayment after Deductible $500 Copayment after Deductible $500 Copayment after Deductible $75 Copayment after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$75 Copayment after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$75 Copayment after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	$50 Copayment after Deductible $50 Copayment after Deductible	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment &	50% Coinsurance after	See Benefit For Description

Braces	Deductible	
External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 $1,000 Copayment per admission after Deductible $75 Copayment after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	$1,000 Copayment per admission after Deductible	See Benefit For Description
Observation Stay	$200 Copayment after Deductible	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac &	$1,000 Copayment per admission after	200 Days Per Plan Year

Pulmonary Rehabilitation) **Preauthorization Required**	Deductible	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	$1,000 Copayment per admission after Deductible	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	$1,000 Copayment per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$75 Copayment after Deductible	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	$1,000 Copayment per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	$75 Copayment after Deductible	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment after Deductible $55 Copayment after Deductible 50% Coinsurance up to	See Benefit For Description

	$750 after Deductible	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment after Deductible $110 Copayment after Deductible 50% Coinsurance up to $1,500 after Deductible	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 $75 Copayment after Deductible $0 Copayment after Deductible $0 Copayment after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
Bronze OAEPO 5000 100% HSA PY SCHEDULE OF BENEFITS
Bronze

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $5,000 $10,000	
Out-of-Pocket Limit • Individual • Family	 $6,250 $12,500	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	0% Coinsurance after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	0% Coinsurance after Deductible	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	

• Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	0% Coinsurance after Deductible	See Benefit For Description
Emergency Department	0% Coinsurance after Deductible	See Benefit For Description
Urgent Care Center	0% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	0% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	0% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	0% Coinsurance after	See Benefits For Description

Preauthorization Required	Deductible	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	0% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	0% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance after Deductible	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services • Home Infusion Therapy	0% Coinsurance after Deductible 0% Coinsurance after Deductible	
Inpatient Medical Visits	0% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered In Full 0% Coinsurance per admission after Deductible 0% Coinsurance per admission after Deductible Covered in Full	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast

Preauthorization Required		feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	0% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	0% Coinsurance after Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	0% Coinsurance after Deductible	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	0% Coinsurance after Deductible	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	0% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	0% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	0% Coinsurance after Deductible 0% Coinsurance after Deductible	See Benefit For Description See Prescription Drug Benefit

Durable Medical Equipment & Braces	50% Coinsurance after Deductible	See Benefit For Description
External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 0% Coinsurance per admission after Deductible 0% Coinsurance after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	0% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	0% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility	0% Coinsurance	200 Days Per Plan Year

(Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	per admission after Deductible	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	0% Coinsurance per admission after Deductible	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	0% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	0% Coinsurance after Deductible	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	0% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	0% Coinsurance after Deductible	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2	$10 Copayment after Deductible $50 Copayment after Deductible	See Benefit For Description

Tier 3	50% Coinsurance up to $750 after Deductible	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment after Deductible $100 Copayment after Deductible 50% Coinsurance up to $1,500 after Deductible	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 0% Coinsurance after Deductible $0 Copayment after Deductible $0 Copayment	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

	after Deductible	

Section XIV.
Gold OAEPO 1000 90% SCHEDULE OF BENEFITS
Gold

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $1,000 $2,000	
Out-of-Pocket Limit • Individual • Family	 $3,000 $6,000	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$30 Copayment	See Benefit For Description
Specialist Office Visits (or Home Visits)	$50 Copayment	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	

• Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	10% Coinsurance after Deductible	See Benefit For Description
Emergency Department Copayment waived if Hospital admission.	$150 Copayment	See Benefit For Description
Urgent Care Center	$75 Copayment	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	10% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	10% Coinsurance after Deductible	See Benefit For Description

Autologous Blood Banking **Preauthorization Required**	10% Coinsurance after Deductible	See Benefits For Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$50 Copayment $50 Copayment 10% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	$50 Copayment	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	$30 Copayment $50 Copayment	See Benefit For Description

• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$50 Copayment	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services • Home Infusion Therapy	10% Coinsurance after Deductible 10% Coinsurance after Deductible	
Inpatient Medical Visits	10% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$30 Copayment 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery	Covered In Full 10% Coinsurance per admission after Deductible 10% Coinsurance per admission after Deductible	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early

• Breast Pump **Preauthorization Required**	Covered in Full	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	10% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	10% Coinsurance After Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$50 Copayment	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$50 Copayment	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$50 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$50 Copayment	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	$30 Copayment $30 Copayment	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment &	50% Coinsurance after	See Benefit For Description

Braces	Deductible	
External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 10% Coinsurance per admission after Deductible 10% Coinsurance after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	10% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	$150 Copayment	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac &	10% Coinsurance per admission after	200 Days Per Plan Year

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

Tier 3	50% Coinsurance up to $750	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment $100 Copayment 50% Coinsurance up to $1,500	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 $50 Copayment $0 Copayment $0 Copayment	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
Silver OAEPO 2000 60% SCHEDULE OF BENEFITS
Silver

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $2,000 $4,000	
Out-of-Pocket Limit • Individual • Family	 $5,500 $11,000	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$30 Copayment	See Benefit For Description
Specialist Office Visits (or Home Visits)	$50 Copayment	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
• Routine Gynecological	Covered in full	

Services/Well Woman Exams*		
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	40% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	40% Coinsurance after Deductible	See Benefit For Description
Emergency Department Copayment waived if Hospital admission.	$200 Copayment	See Benefit For Description
Urgent Care Center	$75 Copayment	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	40% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	40% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	40% Coinsurance after	See Benefits For Description

Preauthorization Required	Deductible	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$50 Copayment $50 Copayment 40% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	$50 Copayment	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	$30 Copayment $50 Copayment	See Benefit For Description

• Performed as Outpatient Hospital Services	40% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$50 Copayment	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services • Home Infusion Therapy	40% Coinsurance after Deductible 40% Coinsurance after Deductible	
Inpatient Medical Visits	40% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$30 Copayment $50 Copayment $50 Copayment	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered In Full 40% Coinsurance per admission after Deductible 40% Coinsurance per admission after Deductible Covered in Full	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast

Preauthorization Required		feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	40% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	40% Coinsurance After Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	$30 Copayment 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$50 Copayment	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$50 Copayment	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$50 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$50 Copayment	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	$30 Copayment $30 Copayment	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment & Braces	50% Coinsurance after Deductible	See Benefit For Description

External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 40% Coinsurance per admission after Deductible 40% Coinsurance after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	40% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	$200 Copayment	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	40% Coinsurance per admission after Deductible	200 Days Per Plan Year

Preauthorization Required		
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	40% Coinsurance per admission after Deductible	60 Days Per Plan Year combined therapies.
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	40% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$50 Copayment	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	40% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	$50 Copayment	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment $50 Copayment 50% Coinsurance up to $750	See Benefit For Description

Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment $100 Copayment 50% Coinsurance up to $1,500	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 $50 Copayment $0 Copayment $0 Copayment	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
Silver OAEPO 2000 80% HSA PY SCHEDULE OF BENEFITS
Silver

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $2,000 $4,000	
Out-of-Pocket Limit • Individual • Family	 $5,000 $10,000	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	20% Coinsurance after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	20% Coinsurance after Deductible	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	

• Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	20% Coinsurance after Deductible	See Benefit For Description
Emergency Department	20% Coinsurance after Deductible	See Benefit For Description
Urgent Care Center	20% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	20% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	20% Coinsurance after	See Benefits For Description

Preauthorization Required	Deductible	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	20% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance after Deductible	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services • Home Infusion Therapy	20% Coinsurance after Deductible 20% Coinsurance after Deductible	
Inpatient Medical Visits	20% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered In Full 20% Coinsurance per admission after Deductible 20% Coinsurance per admission after Deductible Covered in Full	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast

Preauthorization Required		feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	20% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	20% Coinsurance After Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	20% Coinsurance after Deductible	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	20% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	20% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description See Prescription Drug Benefit

Durable Medical Equipment & Braces	50% Coinsurance after Deductible	See Benefit For Description
External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 20% Coinsurance per admission after Deductible 20% Coinsurance after Deductible	 5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	20% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	20% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility	20% Coinsurance	200 Days Per Plan Year

(Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	per admission after Deductible	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	20% Coinsurance per admission after Deductible	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	20% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	20% Coinsurance after Deductible	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	20% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	20% Coinsurance after Deductible	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2	 $10 Copayment after Deductible $50 Copayment after Deductible	See Benefit For Description

Tier 3	50% Coinsurance up to $750 after Deductible	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment after Deductible $100 Copayment after Deductible 50% Coinsurance up to $1,500 after Deductible	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames	 20% Coinsurance after Deductible $0 Copayment after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

• Contact Lenses	$0 Copayment after Deductible	

Section XIV.
Silver OAEPO 2000 90% SCHEDULE OF BENEFITS
Silver

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $2,000 $4,000	
Out-of-Pocket Limit • Individual • Family	 $5,800 $11,600	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$30 Copayment	See Benefit For Description
Specialist Office Visits (or Home Visits)	$50 Copayment	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
• Routine Gynecological	Covered in full	

Services/Well Woman Exams*		
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	10% Coinsurance after Deductible	See Benefit For Description
Emergency Department Copayment waived if Hospital admission.	$200 Copayment	See Benefit For Description
Urgent Care Center	$75 Copayment	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	10% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	10% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	10% Coinsurance after	See Benefits For Description

Preauthorization Required	Deductible	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$50 Copayment $50 Copayment 10% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	$50 Copayment	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	$30 Copayment $50 Copayment	See Benefit For Description

• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$50 Copayment	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services • Home Infusion Therapy	10% Coinsurance after Deductible 10% Coinsurance after Deductible	
Inpatient Medical Visits	10% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$30 Copayment $50 Copayment $50 Copayment	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump	Covered In Full 10% Coinsurance per admission after Deductible 10% Coinsurance per admission after Deductible Covered in Full	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast

Preauthorization Required		feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	10% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	10% Coinsurance After Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	$30 Copayment 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$50 Copayment	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$50 Copayment	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$50 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$50 Copayment	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	$30 Copayment $30 Copayment	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment & Braces	50% Coinsurance after Deductible	See Benefit For Description

External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 10% Coinsurance per admission after Deductible 10% Coinsurance after Deductible	 5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	10% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	$200 Copayment	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	10% Coinsurance per admission after Deductible	200 Days Per Plan Year

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

Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment $100 Copayment 50% Coinsurance up to $1,500	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 $50 Copayment $0 Copayment $0 Copayment	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
Silver OAEPO 3000 70% SCHEDULE OF BENEFITS
Silver

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $3,000 $6,000	
Out-of-Pocket Limit • Individual • Family	 $6,250 $12,500	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$50 Copayment	See Benefit For Description
Specialist Office Visits (or Home Visits)	$75 Copayment	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	

• Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	30% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	30% Coinsurance after Deductible	See Benefit For Description
Emergency Department Copayment waived if Hospital admission.	$200 Copayment	See Benefit For Description
Urgent Care Center	$75 Copayment	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	30% Coinsurance after Deductible 30% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	30% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	30% Coinsurance after Deductible	See Benefit For Description

Autologous Blood Banking **Preauthorization Required**	30% Coinsurance after Deductible	See Benefits For Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$75 Copayment $75 Copayment 30% Coinsurance after Deductible	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	$75 Copayment	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	$50 Copayment $75 Copayment	See Benefit For Description

• Performed as Outpatient Hospital Services	30% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See Benefit For Description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$75 Copayment	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See Benefit For Description

• Performed as Outpatient Hospital Services • Home Infusion Therapy	30% Coinsurance after Deductible 30% Coinsurance after Deductible	
Inpatient Medical Visits	30% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$50 Copayment $75 Copayment $75 Copayment	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery	Covered In Full 30% Coinsurance per admission after Deductible 30% Coinsurance per admission after Deductible	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early

• Breast Pump **Preauthorization Required**	Covered in Full	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	30% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	30% Coinsurance After Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$75 Copayment	60 visits Per Plan Year combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$75 Copayment	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$75 Copayment	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$75 Copayment	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	$50 Copayment $50 Copayment	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment &	50% Coinsurance after	See Benefit For Description

Braces	Deductible	
External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 30% Coinsurance per admission after Deductible 30% Coinsurance after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	30% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	$200 Copayment	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac &	30% Coinsurance per admission after	200 Days Per Plan Year

Pulmonary Rehabilitation) **Preauthorization Required**	Deductible	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	30% Coinsurance per admission after Deductible	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	30% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$75 Copayment	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	30% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	$75 Copayment	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2	 $10 Copayment $50 Copayment	See Benefit For Description

Tier 3	50% Coinsurance up to $750	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $20 Copayment $100 Copayment 50% Coinsurance up to $1,500	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	 Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	 $75 Copayment $0 Copayment $0 Copayment	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

Section XIV.
Silver Indemnity 2500 80% SCHEDULE OF BENEFITS
Silver

COST-SHARING	**Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $2,500 $5,000	
Out-of-Pocket Limit • Individual • Family	 $5,500 $11,000	
OFFICE VISITS	**Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	20% Coinsurance after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	20% Coinsurance after Deductible	See Benefit For Description
PREVENTIVE CARE	**Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
• Routine Gynecological Services/Well Woman	Covered in full	

Exams*		
• Mammogra phy Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectom y	Use Cost Sharing for Appropriate Service	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	20% Coinsurance after Deductible	See Benefit For Description
Emergency Department	20% Coinsurance after Deductible	See Benefit For Description
Urgent Care Center	20% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking **Preauthorization Required**	20% Coinsurance after Deductible	See Benefits For Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office	20% Coinsurance after Deductible	See Benefits For Description

• Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	20% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Dialysis • Performed in a PCP	20% Coinsurance	See Benefit For Description

Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description

Inpatient Medical Visits	20% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump **Preauthorization Required**	Covered In Full 20% Coinsurance per admission after Deductible 20% Coinsurance per admission after Deductible Covered in Full	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	20% Coinsurance After Deductible	See Benefit For Description

Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	60 visits per condition, per lifetime combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	20% Coinsurance after Deductible	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	20% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	20% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment & Braces	50% Coinsurance after Deductible	See Benefit For Description

External Hearing Aids	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 20% Coinsurance per admission after Deductible 20% Coinsurance after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	20% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	20% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	20% Coinsurance per admission after Deductible	200 Days Per Plan Year

Preauthorization Required			
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	20% Coinsurance per admission after Deductible	60 Days Per Plan Year combined therapies	
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Member Responsibility for Cost-Sharing**	**Limits**	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	20% Coinsurance per admission after Deductible	See Benefit For Description	
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	20% Coinsurance after Deductible	See Benefit For Description	
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	20% Coinsurance per admission after Deductible	See Benefit For Description	
Outpatient Substance Use Services	20% Coinsurance after Deductible	Unlimited	
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30 Day Supply Tier 1 Tier 2	$10 Copayment $50 Copayment	$10 Copayment 30% Coinsurance $50 Copayment	See Benefit For Description

Tier 3	50% Coinsurance up to $750	30% Coinsurance 50% Coinsurance up to $750 30% Coinsurance	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	$20 Copayment $100 Copayment 50% Coinsurance up to $1,500	Not Covered Not Covered Not Covered	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**		
Gym Reimbursement	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse	
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Limits**	
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental (Endodontics & Prosthodontics) • Orthodontia	Deductible not applicable 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance, not subject to Deductible	One Dental Exam & Cleaning Per 6-Month Period	
Pediatric Vision Care • Exa ms	20% Coinsurance after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period	

• Lenses & Frames • Contact Lenses	0% Coinsurance 0% Coinsurance	

Section XIV.
Silver OAMC 2000 80/60 SCHEDULE OF BENEFITS
Silver

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $2,000 $4,000	 $4,000 $8,000	
Out-of-Pocket Limit • Individual • Family	 $6,000 $12,000	 $12,000 $24,000 See section IV of the Policy for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount by which the Non-Participating Provider's charge exceeds Our Allowed Amount.	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$40 Copayment	40% Coinsurance after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	$60 Copayment after Deductible	40% Coinsurance after Deductible	See Benefit For Description
PREVENTIVE CARE	**Participating Member**	**Non-Participating Member**	**Limits**

	Responsibility for Cost-Sharing	Responsibility for Cost-Sharing	
• Well Child Visits and Immunizations*	Covered in full	0% Coinsurance	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	40% Coinsurance after Deductible	
• Adult Immunizations*	Covered in full	0% Coinsurance	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	40% Coinsurance after Deductible	
• Mammogra phy Screenings*	Covered in full	40% Coinsurance after Deductible	
• Sterilization Procedures for Women*	Covered in full	40% Coinsurance after Deductible	
• Vasectom y	Use Cost Sharing for Appropriate Service	40% Coinsurance after Deductible	
• Bone Density Testing*	Covered in full	40% Coinsurance after Deductible	

• Screening for Prostate Cancer	Covered in full	40% Coinsurance after Deductible	
• All other preventive services required by USPSTF and HRSA.	Covered in full	40% Coinsurance after Deductible	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Emergency Department Copayment waived if Hospital admission	$200 Copayment	$200 Copayment	See Benefit For Description
Urgent Care Center	$75 Copayment	40% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging			See Benefit

Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	$60 Copayment after Deductible $60 Copayment after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefits For Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as	$60 Copayment after Deductible $60 Copayment after Deductible 20% Coinsurance	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance	See Benefits For Description

Inpatient Hospital Services	after Deductible	after Deductible	
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	$60 Copayment after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$40 Copayment $60 Copayment after Deductible $60 Copayment after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Dialysis • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description Dialysis

• Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	Performed by Non-Participating Providers is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$60 Copayment after Deductible	40% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance	25% Coinsurance	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	40% Coinsurance after Deductible	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description

Inpatient Medical Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$40 Copayment $60 Copayment after Deductible $60 Copayment after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump **Preauthorization Required**	Covered In Full 20% Coinsurance per admission after Deductible 20% Coinsurance per admission after Deductible Covered in Full	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 50% Coinsurance after Deductible	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description

Preadmission Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	$40 Copayment $60 Copayment after Deductible $60 Copayment after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	$60 Copayment after Deductible $60 Copayment after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$60 Copayment after Deductible	40% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$60 Copayment after Deductible	40% Coinsurance after Deductible Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-	See Benefit For Description

		Participating Specialist	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)			See Benefit For Description
• Inpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	**All Transplants Must be Performed at Designated Facilities**
• Outpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Specialist Office Surgery **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$60 Copayment after Deductible	40% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$60 Copayment after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education			See Benefit For Description

• Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	$40 Copayment $40 Copayment	40% Coinsurance after Deductible 40% Coinsurance after Deductible	
Durable Medical Equipment & Braces	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See Benefit For Description
External Hearing Aids	50% Coinsurance after Deductible	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	5% Coinsurance after Deductible	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	20% Coinsurance per admission after Deductible 20% Coinsurance after Deductible	40% Coinsurance per admission after Deductible 40% Coinsurance after Deductible	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	50% Coinsurance after Deductible 50% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description

INPATIENT SERVICES & FACILITIES	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	$200 Copayment	40% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$60 Copayment	40% Coinsurance after Deductible	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See Benefit For Description

Hospital) **Preauthorization Required**			
Outpatient Substance Use Services	$60 Copayment	40% Coinsurance after Deductible	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment $50 Copayment 50% Coinsurance up to $750	 $10 Copayment 30% Coinsurance $50 Copayment 30% Coinsurance 50% Coinsurance up to $750 30% Coinsurance	See Benefit For Description
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment $50 Copayment 50% Coinsurance up to $750	 Not Covered Not Covered Not Covered	See Benefit For Description
WELLNESS BENEFITS	**Participating Member Responsibility for**	**Non-Participating Member Responsibility for**	

	Cost-Sharing	Cost-Sharing	
Gym Reimbursement	Not Applicable	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care			One Dental Exam & Cleaning Per 6-Month Period
• Preventive	0% Coinsurance	40% Coinsurance, not subject deductible	
• Routine Dental Care	30% Coinsurance	50% Coinsurance after Deductible	
• Major Dental (Endodontics & Prosthodontics)	50% Coinsurance	50% Coinsurance after Deductible	
• Orthodontia	50% Coinsurance	50% Coinsurance not subject to Deductible	
• Lifetime Maximum	Not Applicable	$500	
• Out-of-Pocket Maximum	Not Applicable	$500	
Pediatric Vision Care			One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period
• Exa ms	$60 Copayment after Deductible	40% Coinsurance after Deductible	
• Lenses & Frames	0% Coinsurance	40% Coinsurance after Deductible	
• Contact Lenses	0% Coinsurance	40% Coinsurance after Deductible	

Section XIV.
Silver OAMC 2000 80/60 HSA PY SCHEDULE OF BENEFITS
Silver

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $2,000 $4,000	 $4,000 $8,000	
Out-of-Pocket Limit • Individual • Family	 $5,000 $10,000	 $10,000 $20,000 See section IV of the Policy for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount by which the Non-Participating Provider's charge exceeds Our Allowed Amount.	
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description

PREVENTIVE CARE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
• Well Child Visits and Immunizations*	Covered in full	0% Coinsurance	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	40% Coinsurance after Deductible	
• Adult Immunizations*	Covered in full	0% Coinsurance	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	40% Coinsurance after Deductible	
• Mammogra phy Screenings*	Covered in full	40% Coinsurance after Deductible	
• Sterilization Procedures for Women*	Covered in full	40% Coinsurance after Deductible	
• Vasectom y	Use Cost Sharing for Appropriate Service	40% Coinsurance after Deductible	
• Bone Density Testing*	Covered in full	40% Coinsurance after Deductible	

• Screening for Prostate Cancer	Covered in full	40% Coinsurance after Deductible	
• All other preventive services required by USPSTF and HRSA.	Covered in full	40% Coinsurance after Deductible	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Emergency Department	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See Benefit For Description
Urgent Care Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**

Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefits For Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefits For Description

• Performed as Inpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Chiropractic Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description

Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description Dialysis Performed by Non-Participating Providers is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Home Health Care	25% Coinsurance after Deductible	25% Coinsurance after Deductible	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	40% Coinsurance after Deductible	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description

• Home Infusion Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Inpatient Medical Visits	20% Coinsurance	40% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Nurse Midwife Services for Delivery • Breast Pump **Preauthorization Required**	Covered In Full 20% Coinsurance per admission after Deductible 20% Coinsurance per admission after Deductible Covered in Full	40% Coinsurance after Deductible 40% Coinsurance per admission after Deductible 40% Coinsurance per admission after Deductible 50% Coinsurance after Deductible	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding

Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits Per Plan Year combined therapies
Second Opinions on the Diagnosis of Cancer, Surgery & Other	20% Coinsurance after Deductible	40% Coinsurance after Deductible Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)			See Benefit For Description
• Inpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	**All Transplants Must be Performed at Designated Facilities**
• Outpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Specialist Office Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Preauthorization Required			
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	20% Coinsurance after Deductible	40% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education			See Benefit For Description
• Diabetic Equipment, Supplies and Insulin (30-Day Supply)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Diabetic Education	20% Coinsurance after Deductible	40% Coinsurance after Deductible	

Durable Medical Equipment & Braces	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See Benefit For Description
External Hearing Aids	50% Coinsurance after Deductible	50% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance after Deductible	50% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	 20% Coinsurance per admission after Deductible 20% Coinsurance after Deductible	 40% Coinsurance per admission after Deductible 40% Coinsurance after Deductible	 5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	 50% Coinsurance after Deductible 50% Coinsurance after Deductible	 One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See Benefit For Description

Observation Stay	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	60 Days Per Plan Year combined therapies
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required**	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required**	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30 Day Supply Tier 1	$10 Copayment after Deductible	$10 Copayment 30% Coinsurance	See Benefit For Description

		after Deductible	
Tier 2	$50 Copayment after Deductible	$50 Copayment 30% Coinsurance after Deductible	
Tier 3	50% Coinsurance up to $750 after Deductible	50% Coinsurance up to $750 after Deductible 30% Coinsurance	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	$20 Copayment after Deductible	Not Covered	See Benefit For Description
Tier 2	$100 Copayment after Deductible	Not Covered	
Tier 3	50% Coinsurance up to $1,500 after Deductible	Not Covered	
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Not Applicable	Not Applicable	Up to $150 per 12 month period; up to an additional $150 per 12 month period for Spouse
PEDIATRIC DENTAL &VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care			One Dental Exam & Cleaning Per 6-Month Period
• Preventive	0% Coinsurance	40% Coinsurance, not subject deductible	
• Routine Dental Care	30% Coinsurance	50% Coinsurance after Deductible	

• Major Dental (Endodontics & Prosthodontics) • Orthodontia • Lifetime Maximum • Out-of-Pocket Maximum	50% Coinsurance 50% Coinsurance Not Applicable Not Applicable	50% Coinsurance after Deductible 50% Coinsurance not subject to Deductible $500 $500	
Pediatric Vision Care • Exa ms • Lenses & Frames • Contact Lenses	20% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only
Product Name: NY SG ALIC 1Q14-4Q14
Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 1.000%
Effective Date of Last Rate Revision: 01/01/2013
Filing Method of Last Filing: SERFF

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Aetna Life Insurance Company	New Product	0.000%	0.000%	$14,579,129	4,316	$176,938,919	%	%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

State: *New York* **Filing Company:** *Aetna Life Insurance Company*
TOI/Sub-TOI: *H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*
Product Name: *NY SG ALIC 1Q14-4Q14*
Project Name/Number: */*

Rate Review Detail

COMPANY:

Company Name: Aetna Life Insurance Company
HHS Issuer Id: 17210
Product Names: PPO - Aetna Preferred Provider Organization
Indem - Aetna Fee for Service
EPO - Aetna Exclusive Provider Organization
Trend Factors:

FORMS:

New Policy Forms: OffHIXSGEPOGR-96817, OffHIXSGEPOGR-96817-Contra Rider, OffHIXSGEPOGR-96817-Deps Age 29, OffHIXSGEPOGR-96823, OffHIXSGEPOGR-96823-Contra Rider, OffHIXSGEPOGR-96823-Deps Age 29, OffHIXSG(EPObronze2500100%HSAPY)GR-96823-SB, OffHIXSG(EPOBronze350050%)GR-96817-SB, OffHIXSG(EPOBronze350060%HSAPY)GR-96823-SB, OffHIXSG(EPOBronze400080%)GR-96817-SB, OffHIXSG(EPOBronze500060%)GR-96817-SB, OffHIXSG(EPOBronze5000100%HSAPY)GR-96823-SB, OffHIXSG(EPOGold100090%)GR-96817-SB, OffHIXSG(EPOSilver200060%)GR-96817-SB, OffHIXSG(EPOSilver200080%HSAPY)GR-96823-SB, OffHIXSG(EPOSilver200090%)GR-96817-SB, OffHIXSG(EPOSilver300070%)GR-96817-SB, OffHIXSGOAMCGR-96819, OffHIXSGOAMCGR-96819 –Contra Rider, OffHIXSGOAMCGR-96819-Deps Age 29, OffHIXSGOAMCGR-96824, OffHIXSGOAMCGR-96824 –Contra Rider, OffHIXSGOAMCGR-96824-Deps Age 29, OffHIXSG(OAMCSilver80%/60%HSAPY)GR-96824-SB, OffHIXSG(OAMCSilver80%/60%)GR-96819-SB, OffHIXSGINDEMGR-96820, OffHIXSGINDEMGR-96820-Contra Rider, OffHIXSGINDEMGR-96820-Deps Age 29, OffHIXSG(IndemSilver250080%)GR-96820-SB
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
Member Months: 348,588
Benefit Change: None
Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium: 176,938,918.59
Total Incurred Claims: 159,343,544.57
Annual $: Min: 299.00 Max: 3,044.00 Avg: 464.86

REQUESTED RATE:

Projected Earned Premium: 191,518,047.70

State: *New York* **Filing Company:** *Aetna Life Insurance Company*
TOI/Sub-TOI: *H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*
Product Name: *NY SG ALIC 1Q14-4Q14*
Project Name/Number: */*

Projected Incurred Claims: 174,792,082.83
Annual $: Min: 309.00 Max: 2,492.00 Avg: 503.16

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only
Product Name: NY SG ALIC 1Q14-4Q14
Project Name/Number: /

Rate/Rule Schedule

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only
Product Name: NY SG ALIC 1Q14-4Q14
Project Name/Number: /

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments

1		NY SG Rate Manual - ALIC	OffHIXSGEPOGR-96817, OffHIXSGEPOGR-96817-Contra Rider, OffHIXSGEPOGR-96817-Deps Age 29, OffHIXSGEPOGR-96823, OffHIXSGEPOGR-96823-Contra Rider, OffHIXSGEPOGR-96823-Deps Age 29, OffHIXSG(EPObronze2500100%HSAPY)GR-96823-SB, OffHIXSG(EPOBronze350050%)GR-96817-SB, OffHIXSG(EPOBronze350060%HSAPY)GR-96823-SB, OffHIXSG(EPOBronze400080%)GR-96817-SB, OffHIXSG(EPOBronze500060%)GR-96817-SB, OffHIXSG(EPOBronze5000100%HSAPY)GR-96823-SB, OffHIXSG(EPOGold100090%)GR-96817-SB, OffHIXSG(EPOSilver200060%)GR-96817-SB, OffHIXSG(EPOSilver200080%HSAPY)GR-96823-SB, OffHIXSG(EPOSilver200090%)GR-96817-SB, OffHIXSG(EPOSilver300070%)GR-96817-SB,	New		NY SG Rate Manual - ALIC.pdf,

			OffHIXSGOAMCGR-96819, OffHIXSGOAMCGR-96819 –Contra Rider, OffHIXSGOAMCGR-96819-Deps Age 29, OffHIXSGOAMCGR-96824, OffHIXSGOAMCGR-96824 –Contra Rider, OffHIXSGOAMCGR-96824-Deps Age 29, OffHIXSG(OAMCSilver80%/60%HSAPY)GR-96824-SB, OffHIXSG(OAMCSilver80%/60%)GR-96819-SB, OffHIXSGINDEMGR-96820, OffHIXSGINDEMGR-96820-Contra Rider, OffHIXSGINDEMGR-96820-Deps Age 29, OffHIXSG(IndemSilver250080%)GR-96820-SB			

Aetna Life Insurance Company
New York Small Group

Premium Rate Manual

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Aetna Life Insurance Company
New York Small Group

Premium Rate Manual

General

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

Aetna Life Insurance Company
New York Small Group

Premium Rate Manual

The following Steps are used to calculate premium rates.

1. **2014 Base Rate**

Silver Index Premium Rate
$484.86

2. **Plan Pricing Values**

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

   Base Rate x Plan Relativity Factor = Rate for Unique Plan

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

   The plan factors shown on page C-1 - C-3 reflect the pricing differential for each product.

3. **Standardized Rating Region**

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

Rating Region	Counties	Area Factor
Region 1	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	0.9879
Region 2	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	1.1600
Region 3	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster	0.8482
Region 4	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester	0.9689
Region 5	Livingston, Monroe, Ontario, Seneca, Wayne, Yates	0.8400
Region 6	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins	0.9472
Region 7	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	0.9882
Region 8	Nassau, Suffolk	0.9875

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

	PPO
	Effective Date Factor
01/01/2014	1.0000
02/01/2014	1.0000
03/01/2014	1.0000
04/01/2014	1.0251
05/01/2014	1.0251
06/01/2014	1.0251
07/01/2014	1.0510
08/01/2014	1.0510
09/01/2014	1.0510
10/01/2014	1.0775
11/01/2014	1.0775
12/01/2014	1.0775

5. **Standardized Census Tiers**

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

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

6. **Dependent Age Adjustment Factor**

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

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

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

7. **Subscriber Rate**

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

8. **Example of Rate Calculations**

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

<u>Region 1 with OA MC Silver 2000 80 – January 2014</u>

Single:
Round ($484.86*1.128197 * 0.9879 * 1.0 * 1.0*1.0, 0) = $540

Single + Spouse:
Round ($484.86*1.128197 * 0.9879 * 1.0 * 2.0*1.0, 0) = $1081

Single + Child(ren):
Round ($484.86*1.128197 * 0.9879 * 1.0 * 1.7*1.0, 0) = $919

Single + Child(ren) with Dependent Up to Age 30 Rider:
Round ($484.86*1.128197 * 0.9879 * 1.0 * 1.7*1.032, 0) = $948

Single + Spouse + Child(ren)
Round ($484.86*1.128197 * 0.9879 * 1.0 * 2.85*1.0, 0) = $1540

Single + Spouse + Child(ren) with Dependent Up to Age 30 Rider:
Round ($484.86*1.128197 * 0.9879 * 1.0 * 2.85*1.032, 0) = $1589

Region 8 with OA MC Silver 2000 80 – April 2014

Single:
Round ($484.86*1.128197 * 0.9875* 1.0251* 1.0*1.0, 0) = $554

Single + Spouse:
Round ($484.86*1.128197 * 0.9875* 1.0251* 2.0*1.0, 0) = $1108

Single + Child(ren):
Round ($484.86*1.128197 * 0.9875* 1.0251 * 1.7*1.0, 0) = $941

Single + Child(ren) with Dependent Up to Age 30 Rider:
Round ($484.86*1.128197 * 0.9875* 1.0251* 1.7*1.032, 0) = $972

Single + Spouse + Child(ren)
Round ($484.86*1.128197 * 0.9875* 1.0251* 2.85*1.0, 0) = $1578

Single + Spouse + Child(ren) with Dependent Up to Age 30 Rider:
Round ($484.86*1.128197 * 0.9875* 1.0251 * 2.85*1.032, 0) = $1629

Aetna Life Insurance Company
New York Small Group PPO Filing
SERFF ID: AETN-128993202
Exhibit B

New York Small Group PPO Portfolio | Summary of Benefits

Contents

NY BRONZE OAEPO 2500 100% HSA PY 2
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NY BRONZE OAEPO 5000 100% HSA PY 10
NY BRONZE OAEPO 5000 60% 12
NY SILVER INDEMNITY 2500 80% 14
NY SILVER OAEPO 2000 60% 16
NY SILVER OAEPO 2000 80% HSA PY 18
NY SILVER OAEPO 2000 90% 20
NY SILVER OAEPO 3000 70% 22
NY SILVER OAMC 2000 80/60 24
NY SILVER OAMC 2000 80/60 HSA PY 26
NY GOLD OAEPO 1000 90% 28
NY BRONZE OAEPO 2500 100% HSA PY RE 30
NY BRONZE OAEPO 3500 50% RE 32
NY BRONZE OAEPO 3500 60% HSA PY RE 34
NY BRONZE OAEPO 4000 80% RE 36
NY BRONZE OAEPO 5000 100% HSA PY RE 38
NY BRONZE OAEPO 5000 60% RE 40
NY SILVER INDEMNITY 2500 80% RE 42
NY SILVER OAEPO 2000 60% RE 44
NY SILVER OAEPO 2000 80% HSA PY RE 46
NY SILVER OAEPO 2000 90% RE 48
NY SILVER OAEPO 3000 70% RE 50
NY SILVER OAMC 2000 80/60 RE 52
NY SILVER OAMC 2000 80/60 HSA PY RE 54
NY GOLD OAEPO 1000 90% RE 56

Summary of Benefits Covered

NY BRONZE OAEPO 2500 100% HSA PY

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$2,500
Family	$5,000
Coinsurance *(Member Responsibility)*	0%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit after deductible
Specialist Visit	$75 per visit after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	$1,000/Admit after deductible
Emergency Room Services	$200 per visit after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$75 per visit after deductible
Imaging (CT/PET Scans, MRIs)	$75 per visit after deductible
Rehabilitative Speech Therapy	$75 per visit after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$75 per visit after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$75 per visit after deductible
X-rays and Diagnostic Imaging	$75 per visit after deductible
Skilled Nursing Facility	$1,000/Admit after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$500 per visit after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible

Pharmacy	In-Network
Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	$10 copay
Preferred Brand Drugs	$55 copay
Non-Preferred Brand Drugs	50% up to $750
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$2,500.00	$2,500.00			
Coinsurance (%, Insurer's Cost Share)	100.00%		100.00%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$50.00	☑	☑		
Specialist Visit	☑	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$75.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$75.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$75.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	76%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	89%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$55.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$55.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.2%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 2500 100% HSA PY, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.2%.

Summary of Benefits Covered

NY BRONZE OAEPO 3500 50%

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$3,500
Family	$7,000
Coinsurance *(Member Responsibility)*	50%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,800
Familiy	$11,600
	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)	50% after deductible
Specialist Visit	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	50% after deductible
Emergency Room Services	50% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	50% after deductible
Imaging (CT/PET Scans, MRIs)	50% after deductible
Rehabilitative Speech Therapy	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	50% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	50% after deductible
X-rays and Diagnostic Imaging	50% after deductible
Skilled Nursing Facility	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	50% after deductible
Outpatient Surgery Physician/Surgical Services	50% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$3,500.00	$3,500.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)	$5,800.00		$5,800.00			
OOP Maximum if Separate ($)	$5,800.00	$0.00				

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.9%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 3500 50%, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.9%.

Summary of Benefits Covered

NY BRONZE OAEPO 3500 60% HSA PY

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$3,500
Family	$7,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	40% after deductible
Specialist Visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	40% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	40% after deductible
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	40% after deductible
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$61.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$3,500.00	$3,500.00			
Coinsurance (%, Insurer's Cost Share)			59.68%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	60%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	60%		☑	☑		
Specialist Visit	☑	☐	60%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	60%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	60%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	60%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	60%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	62.0%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 3500 60% HSA PY, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 62.0%

Summary of Benefits Covered

NY BRONZE OAEPO 4000 80%

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$4,000
Family	$8,000
Coinsurance *(Member Responsibility)*	20%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,000
Familiy	$12,000
	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)	$25 per visit after deductible
Specialist Visit	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible
Emergency Room Services	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible
Rehabilitative Speech Therapy	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible
Skilled Nursing Facility	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$4,000.00	$4,000.00	$4,000.00			
Coinsurance (%, Insurer's Cost Share)			78.99%			
OOP Maximum ($)	$6,000.00		$6,000.00			
OOP Maximum if Separate ($)	$6,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separat
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.3%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 4000 80%, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.3%.

Summary of Benefits Covered

NY BRONZE OAEPO 5000 100% HSA PY

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$5,000
Family	$10,000
Coinsurance *(Member Responsibility)*	0%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	0% after deductible
Specialist Visit	0% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	0% after deductible
Emergency Room Services	0% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	0% after deductible
Imaging (CT/PET Scans, MRIs)	0% after deductible
Rehabilitative Speech Therapy	0% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	0% after deductible
X-rays and Diagnostic Imaging	0% after deductible
Skilled Nursing Facility	0% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$68.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$5,000.00	$5,000.00			
Coinsurance (%, Insurer's Cost Share)	100.00%		100.00%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.7%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 5000 100% HSA PY satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.7%.

Summary of Benefits Covered

NY BRONZE OAEPO 5000 60%

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$5,000
Family	$10,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit
Specialist Visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	40% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	40%
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	40% after deductible
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

Pharmacy	In-Network
Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	$10 copay
Preferred Brand Drugs	50% if no GE available
Non-Preferred Brand Drugs	Not Covered
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$5,000.00	$5,000.00			
Coinsurance (%, Insurer's Cost Share)			58.18%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	60%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☑	☑	60%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	60%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	60%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	60%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	60%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☑	50%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.4%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 5000 60% satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.4%.

Summary of Benefits Covered

NY SILVER INDEMNITY 2500 80%

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible Individual Family		 $2,500 $5,000
Coinsurance *(Member Responsibility)*		20%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum Individual Familiy		 $5,500 $11,000
	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)	$25 per visit after deductible	20% after deductible
Specialist Visit	20% after deductible	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	20% after deductible
Emergency Room Services	20% after deductible	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	20% after deductible
Rehabilitative Speech Therapy	20% after deductible	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	20% after deductible
Preventive Care/Screening/Immunization	0%	0%
Laboratory Outpatient and Professional Services	20% after deductible	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible	20% after deductible
Skilled Nursing Facility	20% after deductible	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	20% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible Individual Family	 N/A N/A	 N/A N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as applicable INN tier cost share + 30%

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	Silver

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

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$2,500.00	$0.00	$2,500.00
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%	
OOP Maximum ($)	$5,500.00		$5,500.00
OOP Maximum if Separate ($)	$5,500.00	$0.00	

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.6%
Metal Tier:	Silver

This product, NY Silver Indemnity 2500 80% satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.6%.

Summary of Benefits Covered

NY SILVER OAEPO 2000 60%

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,500
Familiy	$11,000
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$50 per visit
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	60.00%	50.00%				
OOP Maximum ($)	$5,500.00		$5,500.00			
OOP Maximum if Separate ($)	$5,500.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.8%
Metal Tier:	Silver

This product, NY SILVER OAEPO 2000 60%, satisfies the HHS guidelines a Silver plan with an Actuarial Value of 71.8%

Summary of Benefits Covered

NY SILVER OAEPO 2000 80% HSA PY

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	20%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,000
Familiy	$10,000
	All cost sharing accumulates to the Out of Pocket Maximum above
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	20% after deductible
Specialist Visit	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible
Emergency Room Services	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible
Rehabilitative Speech Therapy	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible
Skilled Nursing Facility	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$262.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$2,000.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)			78.87%			
OOP Maximum ($)	$5,000.00		$5,000.00			
OOP Maximum if Separate ($)	$5,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY Silver OAEPO 2000 80% HSA PY, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%

Summary of Benefits Covered

NY SILVER OAEPO 2000 90%

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible Individual Family	 $2,000 $4,000
Coinsurance *(Member Responsibility)*	10%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum Individual Familiy	 $5,800 $11,600
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	10% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$50 per visit
X-rays and Diagnostic Imaging	10% after deductible
Skilled Nursing Facility	10% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%	
OOP Maximum ($)	$5,800.00		$5,800.00
OOP Maximum if Separate ($)	$5,800.00	$0.00	

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	90%		☑	☑		
Skilled Nursing Facility	☑	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY Silver OAEPO 2000 90% satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%.

Summary of Benefits Covered

NY SILVER OAEPO 3000 70%

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$3,000
Family	$6,000
Coinsurance *(Member Responsibility)*	30%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit
Specialist Visit	$75 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	30% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$75 per visit
Imaging (CT/PET Scans, MRIs)	30% after deductible
Rehabilitative Speech Therapy	$75 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$75 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$75 per visit
X-rays and Diagnostic Imaging	30% after deductible
Skilled Nursing Facility	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% after deductible
Outpatient Surgery Physician/Surgical Services	30% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$0.00	$3,000.00			
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%				
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$75.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	70%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$75.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$75.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	70%		☑	☑		
Skilled Nursing Facility	☑	☑	70%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	70%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	70%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.3%
Metal Tier:	Silver

This product, NY Silver OAEPO 3000 70%, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.3%.

Summary of Benefits Covered

NY SILVER OAMC 2000 80/60

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance *(Member Responsibility)*	20%	40%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$6,000	$12,000
Familiy	$12,000	$24,000
	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)	$40 per visit	40% after deductible
Specialist Visit	$60 per visit after deductible	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	40% after deductible
Emergency Room Services	$200 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$60 per visit	40% after deductible
Imaging (CT/PET Scans, MRIs)	$60 per visit after deductible	40% after deductible
Rehabilitative Speech Therapy	$60 per visit after deductible	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$60 per visit after deductible	40% after deductible
Preventive Care/Screening/Immunization	0%	40% after deductible
Laboratory Outpatient and Professional Services	$60 per visit after deductible	40% after deductible
X-rays and Diagnostic Imaging	$60 per visit after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 copay + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as INN applicable tier cost share + 30%

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?	☐
e Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%				
OOP Maximum ($)	$6,000.00		$6,000.00			
OOP Maximum if Separate ($)	$6,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$60.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$60.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$60.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$60.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$60.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$60.00	☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
gin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.8%
Metal Tier:	Silver

This product, NY Silver OAMC 2000 80/60 satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.8%

Summary of Benefits Covered

NY SILVER OAMC 2000 80/60 HSA PY

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance *(Member Responsibility)*	20%	40%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$5,000	$10,000
Familiy	$10,000	$20,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	20% after deductible	40% after deductible
Specialist Visit	20% after deductible	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	40% after deductible
Emergency Room Services	20% after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible	40% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	40% after deductible
Rehabilitative Speech Therapy	20% after deductible	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	40% after deductible
Preventive Care/Screening/Immunization	0%	40% after deductible
Laboratory Outpatient and Professional Services	20% after deductible	40% after deductible
X-rays and Diagnostic Imaging	20% after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 copay + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as applicable INN tier cost share + 30%

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?	☐
e Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☑
Annual Contribution Amount:	$262.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$2,000.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)			78.87%			
OOP Maximum ($)	$5,000.00		$5,000.00			
OOP Maximum if Separate ($)	$5,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
gin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY SILVER OAMC 2000 80/60 HSA PY, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%

Summary of Benefits Covered

NY GOLD OAEPO 1000 90%

New York Small Group

Gold Plan

Summary of Features	In-Network
Deductible	
Individual	$1,000
Family	$2,000
Coinsurance *(Member Responsibility)*	10%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$3,000
Familiy	$6,000
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible
Emergency Room Services	$150 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	10% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	10% after deductible
X-rays and Diagnostic Imaging	10% after deductible
Skilled Nursing Facility	10% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00	$1,000.00			
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%				
OOP Maximum ($)	$3,000.00		$3,000.00			
OOP Maximum if Separate ($)	$3,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☐	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	90%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	90%		☑	☑		
Skilled Nursing Facility	☑	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.3%
Metal Tier:	Gold

This product, NY Gold OAEPO 1000 90%, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.3%.

Summary of Benefits Covered

NY BRONZE OAEPO 2500 100% HSA PY RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible Individual Family	 $2,500 $5,000
Coinsurance *(Member Responsibility)*	0%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum Individual Familiy	 $6,250 $12,500
	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)	$50 per visit after deductible
Specialist Visit	$75 per visit after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	$1,000/Admit after deductible
Emergency Room Services	$200 per visit after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$75 per visit after deductible
Imaging (CT/PET Scans, MRIs)	$75 per visit after deductible
Rehabilitative Speech Therapy	$75 per visit after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$75 per visit after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$75 per visit after deductible
X-rays and Diagnostic Imaging	$75 per visit after deductible
Skilled Nursing Facility	$1,000/Admit after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$500 per visit after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible

Pharmacy	In-Network
Pharmacy Deductible Individual Family	 N/A N/A
Generics	$10 copay
Preferred Brand Drugs	$55 copay
Non-Preferred Brand Drugs	50% up to $750
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$2,500.00	$2,500.00	$2,500.00
Coinsurance (%, Insurer's Cost Share)	100.00%		100.00%
OOP Maximum ($)	$6,250.00		$6,250.00
OOP Maximum if Separate ($)	$6,250.00	$0.00	

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$50.00	☑	☑		
Specialist Visit	☑	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$75.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$75.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$75.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	76%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	89%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$55.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$55.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.2%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 2500 100% HSA PY RE, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.2%.

Summary of Benefits Covered

NY BRONZE OAEPO 3500 50% RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible Individual Family	 $3,500 $7,000
Coinsurance *(Member Responsibility)*	50%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum Individual Familiy	 $5,800 $11,600
	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)	50% after deductible
Specialist Visit	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	50% after deductible
Emergency Room Services	50% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	50% after deductible
Imaging (CT/PET Scans, MRIs)	50% after deductible
Rehabilitative Speech Therapy	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	50% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	50% after deductible
X-rays and Diagnostic Imaging	50% after deductible
Skilled Nursing Facility	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	50% after deductible
Outpatient Surgery Physician/Surgical Services	50% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$3,500.00	$3,500.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)	$5,800.00		$5,800.00			
OOP Maximum if Separate ($)	$5,800.00	$0.00				

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.9%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 3500 50% RE, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.9%.

Summary of Benefits Covered

NY BRONZE OAEPO 3500 60% HSA PY RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible Individual Family	 $3,500 $7,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum Individual Familiy	 $6,250 $12,500
	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)	40% after deductible
Specialist Visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	40% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	40% after deductible
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	40% after deductible
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$61.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$3,500.00	$3,500.00			
Coinsurance (%, Insurer's Cost Share)			59.68%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	60%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	60%		☑	☑		
Specialist Visit	☑	☐	60%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	60%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	60%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	60%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	60%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	62.0%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 3500 60% HSA PY RE, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 62.0%

Summary of Benefits Covered

NY BRONZE OAEPO 4000 80% RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$4,000
Family	$8,000
Coinsurance *(Member Responsibility)*	20%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,000
Familiy	$12,000
	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)	$25 per visit after deductible
Specialist Visit	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible
Emergency Room Services	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible
Rehabilitative Speech Therapy	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible
Skilled Nursing Facility	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$4,000.00	$4,000.00	$4,000.00			
Coinsurance (%, Insurer's Cost Share)			78.99%			
OOP Maximum ($)	$6,000.00		$6,000.00			
OOP Maximum if Separate ($)	$6,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separat
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.3%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 4000 80% RE, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.3%.

Summary of Benefits Covered

NY BRONZE OAEPO 5000 100% HSA PY RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible Individual Family	 $5,000 $10,000
Coinsurance *(Member Responsibility)*	0% *$0 once out-of-pocket max. is satisfied*
Out-of-Pocket Maximum Individual Familiy	 $6,250 $12,500 *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)	0% after deductible
Specialist Visit	0% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	0% after deductible
Emergency Room Services	0% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	0% after deductible
Imaging (CT/PET Scans, MRIs)	0% after deductible
Rehabilitative Speech Therapy	0% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	0% after deductible
X-rays and Diagnostic Imaging	0% after deductible
Skilled Nursing Facility	0% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$68.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$5,000.00	$5,000.00			
Coinsurance (%, Insurer's Cost Share)	100.00%		100.00%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.7%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 5000 100% HSA PY RE satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.7%.

Summary of Benefits Covered

NY BRONZE OAEPO 5000 60% RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$5,000
Family	$10,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit
Specialist Visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	40% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	40%
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	40% after deductible
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

Pharmacy	In-Network
Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	$10 copay
Preferred Brand Drugs	50% if no GE available
Non-Preferred Brand Drugs	Not Covered
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$5,000.00	$5,000.00			
Coinsurance (%, Insurer's Cost Share)			58.18%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	60%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☑	☑	60%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	60%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	60%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	60%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	60%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☑	50%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.4%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 5000 60% RE satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.4%.

Summary of Benefits Covered

NY SILVER INDEMNITY 2500 80% RE

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual		$2,500
Family		$5,000
Coinsurance *(Member Responsibility)*		20%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual		$5,500
Familiy		$11,000
	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)	$25 per visit after deductible	20% after deductible
Specialist Visit	20% after deductible	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	20% after deductible
Emergency Room Services	20% after deductible	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	20% after deductible
Rehabilitative Speech Therapy	20% after deductible	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	20% after deductible
Preventive Care/Screening/Immunization	0%	0%
Laboratory Outpatient and Professional Services	20% after deductible	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible	20% after deductible
Skilled Nursing Facility	20% after deductible	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	20% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as applicable INN tier cost share + 30%

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	Silver

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$0.00	$2,500.00			
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%				
OOP Maximum ($)	$5,500.00		$5,500.00			
OOP Maximum if Separate ($)	$5,500.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.6%
Metal Tier:	Silver

This product, NY Silver Indemnity 2500 80% RE satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.6%.

Summary of Benefits Covered

NY SILVER OAEPO 2000 60% RE

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,500
Familiy	$11,000
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$50 per visit
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	60.00%	50.00%				
OOP Maximum ($)	$5,500.00		$5,500.00			
OOP Maximum if Separate ($)	$5,500.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.8%
Metal Tier:	Silver

This product, NY SILVER OAEPO 2000 60% RE, satisfies the HHS guidelines a Silver plan with an Actuarial Value of 71.8%

Summary of Benefits Covered

NY SILVER OAEPO 2000 80% HSA PY RE

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	20%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,000
Familiy	$10,000
	All cost sharing accumulates to the Out of Pocket Maximum above
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	20% after deductible
Specialist Visit	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible
Emergency Room Services	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible
Rehabilitative Speech Therapy	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible
Skilled Nursing Facility	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan? ☐
Annual Contribution Amount:	$262.00	1st Tier Utilization:
		2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$2,000.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)			78.87%			
OOP Maximum ($)	$5,000.00		$5,000.00			
OOP Maximum if Separate ($)	$5,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY Silver OAEPO 2000 80% HSA PY RE, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%

Summary of Benefits Covered

NY SILVER OAEPO 2000 90% RE

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	10%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,800
Familiy	$11,600
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	10% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$50 per visit
X-rays and Diagnostic Imaging	10% after deductible
Skilled Nursing Facility	10% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%				
OOP Maximum ($)	$5,800.00		$5,800.00			
OOP Maximum if Separate ($)	$5,800.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	90%		☑	☑		
Skilled Nursing Facility	☑	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY Silver OAEPO 2000 90% RE satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%.

Summary of Benefits Covered

NY SILVER OAEPO 3000 70% RE

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$3,000
Family	$6,000
Coinsurance *(Member Responsibility)*	30%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit
Specialist Visit	$75 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	30% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$75 per visit
Imaging (CT/PET Scans, MRIs)	30% after deductible
Rehabilitative Speech Therapy	$75 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$75 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$75 per visit
X-rays and Diagnostic Imaging	30% after deductible
Skilled Nursing Facility	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% after deductible
Outpatient Surgery Physician/Surgical Services	30% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$0.00	$3,000.00			
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%				
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$75.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	70%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$75.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$75.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	70%		☑	☑		
Skilled Nursing Facility	☑	☑	70%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	70%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	70%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.3%
Metal Tier:	Silver

This product, NY Silver OAEPO 3000 70% RE, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.3%.

Summary of Benefits Covered

NY SILVER OAMC 2000 80/60 RE

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance *(Member Responsibility)*	20%	40%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$6,000	$12,000
Familiy	$12,000	$24,000
	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)	$40 per visit	40% after deductible
Specialist Visit	$60 per visit after deductible	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	40% after deductible
Emergency Room Services	$200 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$60 per visit	40% after deductible
Imaging (CT/PET Scans, MRIs)	$60 per visit after deductible	40% after deductible
Rehabilitative Speech Therapy	$60 per visit after deductible	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$60 per visit after deductible	40% after deductible
Preventive Care/Screening/Immunization	0%	40% after deductible
Laboratory Outpatient and Professional Services	$60 per visit after deductible	40% after deductible
X-rays and Diagnostic Imaging	$60 per visit after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 copay + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as INN applicable tier cost share + 30%

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?	☐
e Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%				
OOP Maximum ($)	$6,000.00		$6,000.00			
OOP Maximum if Separate ($)	$6,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$60.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$60.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$60.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$60.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$60.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$60.00	☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
gin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.8%
Metal Tier:	Silver

This product, NY Silver OAMC 2000 80/60 RE satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.8%

Summary of Benefits Covered

NY SILVER OAMC 2000 80/60 HSA PY RE

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance *(Member Responsibility)*	20%	40%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$5,000	$10,000
Familiy	$10,000	$20,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	20% after deductible	40% after deductible
Specialist Visit	20% after deductible	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	40% after deductible
Emergency Room Services	20% after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible	40% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	40% after deductible
Rehabilitative Speech Therapy	20% after deductible	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	40% after deductible
Preventive Care/Screening/Immunization	0%	40% after deductible
Laboratory Outpatient and Professional Services	20% after deductible	40% after deductible
X-rays and Diagnostic Imaging	20% after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 copay + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as applicable INN tier cost share + 30%

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?	☐
e Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☑
Annual Contribution Amount:	$262.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$2,000.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)			78.87%			
OOP Maximum ($)	$5,000.00		$5,000.00			
OOP Maximum if Separate ($)	$5,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
gin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY SILVER OAMC 2000 80/60 HSA PY RE, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%

Summary of Benefits Covered

NY GOLD OAEPO 1000 90% RE

New York Small Group

Gold Plan

Summary of Features	In-Network
Deductible	
Individual	$1,000
Family	$2,000
Coinsurance *(Member Responsibility)*	10%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$3,000
Familiy	$6,000
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible
Emergency Room Services	$150 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	10% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	10% after deductible
X-rays and Diagnostic Imaging	10% after deductible
Skilled Nursing Facility	10% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00	$1,000.00			
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%				
OOP Maximum ($)	$3,000.00		$3,000.00			
OOP Maximum if Separate ($)	$3,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☐	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	90%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	90%		☑	☑		
Skilled Nursing Facility	☑	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? ☑
Specialty Rx Coinsurance Maximum: $750

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

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

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

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 79.3%
Metal Tier: Gold

This product, NY Gold OAEPO 1000 90% RE, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.3%.

Plan Relativity Factors

Table 1 - **EPO**

New Plan Name	Plan Relativity Factor	Rx Generic	Rx Brand Formulary	Rx Brand Non-Formulary	INN Coins	INN Deductible	INN OOP Max	Primary Copay	Specialist Copay	SPU Copay	Hospital Copay	ER Copay
OA EPO Bronze 3500 50	0.822905	$10	$50	50% up to $750	50%	$3,500	$5,800	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO Bronze 4000 80	0.805746	$10	$50	50% up to $750	80%	$4,000	$6,000	$25	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO Bronze 5000 60	0.764662	$10	50% if no GE available	Not Covered	60%	$5,000	$6,250	$50	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO HSA Comp 2500 100 PY	0.832210	$10	$55	50% up to $750	100%	$2,500	$6,250	$50	$75	Plan Coins	$1000 / admit	$200
OA EPO HSA Comp 3500 60 PY	0.811728	$10	$50	50% up to $750	60%	$3,500	$6,250	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO HSA Comp 5000 100 PY	0.804901	$10	$50	50% up to $750	100%	$5,000	$6,250	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO Silver 3000 70	0.972807	$10	$50	50% up to $750	70%	$3,000	$6,250	$50	$75	Plan Coins	Plan Coins	$200
OA EPO Silver 2000 60	1.058177	$10	$50	50% up to $750	60%	$2,000	$5,500	$30	$50	Plan Coins	Plan Coins	$200
OA EPO Silver 2000 90	1.127418	$10	$50	50% up to $750	90%	$2,000	$5,800	$30	$50	Plan Coins	Plan Coins	$200
OA EPO HSA Comp 2000 80 PY	1.028010	$10	$50	50% up to $750	80%	$2,000	$5,000	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO Gold 1000 90	1.230652	$10	$50	50% up to $750	90%	$1,000	$3,000	$30	$50	Plan Coins	Plan Coins	$150
OA EPO Bronze 3500 50 RE	0.817185	$10	$50	50% up to $750	50%	$3,500	$5,800	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO Bronze 4000 80 RE	0.800145	$10	$50	50% up to $750	80%	$4,000	$6,000	$25	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO Bronze 5000 60 RE	0.759346	$10	50% if no GE available	Not Covered	60%	$5,000	$6,250	$50	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO HSA Comp 2500 100 PY RE	0.826425	$10	$55	50% up to $750	100%	$2,500	$6,250	$50	$75	Plan Coins	$1000 / admit	$200
OA EPO HSA Comp 3500 60 PY RE	0.806085	$10	$50	50% up to $750	60%	$3,500	$6,250	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO HSA Comp 5000 100 PY RE	0.799305	$10	$50	50% up to $750	100%	$5,000	$6,250	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO Silver 3000 70 RE	0.958431	$10	$50	50% up to $750	70%	$3,000	$6,250	$50	$75	Plan Coins	Plan Coins	$200
OA EPO Silver 2000 60 RE	1.042539	$10	$50	50% up to $750	60%	$2,000	$5,500	$30	$50	Plan Coins	Plan Coins	$200
OA EPO Silver 2000 90 RE	1.110757	$10	$50	50% up to $750	90%	$2,000	$5,800	$30	$50	Plan Coins	Plan Coins	$200
OA EPO HSA Comp 2000 80 PY RE	1.012817	$10	$50	50% up to $750	80%	$2,000	$5,000	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA EPO Gold 1000 90 RE	1.212465	$10	$50	50% up to $750	90%	$1,000	$3,000	$30	$50	Plan Coins	Plan Coins	$150

Plan Relativity Factors

Table 2 - **Indemnity**

New Plan Number	Plan Relativity Factor	Rx Generic	Rx Brand Formulary	Rx Brand Non-Formulary	OON Coins	OON Deductible	OOP Max	Primary Copay	Specialist Copay	SPU Copay	Hospital Copay	ER Copay
Indemnity Silver 2500 80	1.398136	$10	$50	50% up to $750	20%	$2,500	$5,500	$25	Plan Coins	Plan Coins	Plan Coins	Plan Coins
Indemnity Silver 2500 80 RE	1.377473	$10	$50	50% up to $750	20%	$2,500	$5,500	$25	Plan Coins	Plan Coins	Plan Coins	Plan Coins

Plan Relativity Factors

Table 3 - **MC**

New Plan Number	Plan Relativity Factor	Rx Generic	Rx Brand Formulary	Rx Brand Non-Formulary	INN Coins	INN Deductible	INN OOP Max	OON Coins	OON Deductible	OON OOP Max	INN Primary Copay	INN Specialist Copay	INN SPU Copay	INN Hospital Copay	INN ER Copay
OA MC Silver 2000 80	1.072666	$10	$50	50% up to $750	80%	$2,000	$6,000	60%	$ 4,000	$12,000	$40	$60	Plan Coins	Plan Coins	$200
OA MC HSA Comp 2000 80 PY	1.072666	$10	$50	50% up to $750	80%	$2,000	$5,000	60%	$ 4,000	$10,000	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins
OA MC Silver 2000 80 RE	1.111524	$10	$50	50% up to $750	80%	$2,000	$6,000	60%	$ 4,000	$12,000	$40	$60	Plan Coins	Plan Coins	$200
OA MC HSA Comp 2000 80 PY RE	1.056814	$10	$50	50% up to $750	80%	$2,000	$5,000	60%	$ 4,000	$10,000	Plan Coins	Plan Coins	Plan Coins	Plan Coins	Plan Coins

Aetna Life Insurance Company
New York Small Group

Premium Rates

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

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA01

New Plan Number	Plan	Single Premium Rate 1Q 2014	Parent & Child(ren) Premium Rate 1Q 2014	Couple Premium Rate 1Q 2014	Family Premium Rate 1Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 1Q 2014	With dependent up to age 30 rider: Family Premium Rate 1Q 2014
14018887	EPO	$394	$670	$788	$1,123	$692	$1,159
14018888	EPO	$386	$656	$772	$1,100	$677	$1,135
14018889	EPO	$366	$623	$733	$1,044	$643	$1,077
14018892	EPO	$399	$678	$797	$1,136	$699	$1,172
14018894	EPO	$389	$661	$778	$1,108	$682	$1,144
14018893	EPO	$386	$655	$771	$1,099	$676	$1,134
14018886	EPO	$466	$792	$932	$1,328	$817	$1,371
14018884	EPO	$507	$862	$1,014	$1,445	$889	$1,491
14018885	EPO	$540	$918	$1,080	$1,539	$947	$1,588
14018890	MC	$540	$919	$1,081	$1,540	$948	$1,589
14018895	MC	$514	$873	$1,028	$1,464	$901	$1,511
14018891	EPO	$492	$837	$985	$1,403	$864	$1,448
14018896	Indemnity	$670	$1,138	$1,339	$1,909	$1,175	$1,970
14018883	EPO	$589	$1,002	$1,179	$1,680	$1,034	$1,734
14018901	EPO	$391	$665	$783	$1,116	$687	$1,151
14018902	EPO	$383	$652	$767	$1,092	$672	$1,127
14018903	EPO	$364	$618	$727	$1,037	$638	$1,070
14018904	EPO	$396	$673	$792	$1,128	$694	$1,164
14018906	EPO	$386	$656	$772	$1,100	$677	$1,136
14018907	EPO	$383	$651	$766	$1,091	$672	$1,126
14018900	EPO	$459	$780	$918	$1,308	$805	$1,350
14018899	EPO	$499	$849	$999	$1,423	$876	$1,469
14018898	EPO	$532	$904	$1,064	$1,516	$933	$1,565
14018912	MC	$532	$905	$1,065	$1,517	$934	$1,566
14018913	MC	$506	$861	$1,012	$1,443	$888	$1,489
14018905	EPO	$485	$825	$970	$1,383	$851	$1,427
14018908	Indemnity	$660	$1,122	$1,320	$1,880	$1,158	$1,941
14018897	EPO	$581	$987	$1,162	$1,655	$1,019	$1,708

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA01

New Plan Number	Plan	Single Premium Rate 2Q 2014	Parent & Child(ren) Premium Rate 2Q 2014	Couple Premium Rate 2Q 2014	Family Premium Rate 2Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 2Q 2014	With dependent up to age 30 rider: Family Premium Rate 2Q 2014
14018887	EPO	$404	$687	$808	$1,152	$709	$1,188
14018888	EPO	$396	$673	$791	$1,128	$694	$1,164
14018889	EPO	$375	$638	$751	$1,070	$659	$1,104
14018892	EPO	$409	$695	$817	$1,165	$717	$1,202
14018894	EPO	$399	$678	$797	$1,136	$699	$1,172
14018893	EPO	$395	$672	$790	$1,126	$693	$1,162
14018886	EPO	$478	$812	$955	$1,361	$838	$1,405
14018884	EPO	$520	$883	$1,039	$1,481	$912	$1,528
14018885	EPO	$554	$941	$1,107	$1,578	$971	$1,628
14018890	MC	$554	$942	$1,108	$1,579	$972	$1,629
14018895	MC	$527	$895	$1,053	$1,501	$924	$1,549
14018891	EPO	$505	$858	$1,010	$1,439	$886	$1,485
14018896	Indemnity	$687	$1,167	$1,373	$1,957	$1,204	$2,019
14018883	EPO	$604	$1,027	$1,209	$1,722	$1,060	$1,777
14018901	EPO	$401	$682	$803	$1,144	$704	$1,180
14018902	EPO	$393	$668	$786	$1,120	$689	$1,156
14018903	EPO	$373	$634	$746	$1,063	$654	$1,097
14018904	EPO	$406	$690	$812	$1,157	$712	$1,194
14018906	EPO	$396	$673	$792	$1,128	$694	$1,164
14018907	EPO	$392	$667	$785	$1,119	$689	$1,154
14018900	EPO	$471	$800	$941	$1,341	$826	$1,384
14018899	EPO	$512	$870	$1,024	$1,459	$898	$1,506
14018898	EPO	$545	$927	$1,091	$1,554	$957	$1,604
14018912	MC	$546	$928	$1,092	$1,556	$958	$1,605
14018913	MC	$519	$882	$1,038	$1,479	$910	$1,526
14018905	EPO	$497	$845	$995	$1,417	$873	$1,463
14018908	Indemnity	$676	$1,150	$1,353	$1,928	$1,187	$1,989
14018897	EPO	$595	$1,012	$1,191	$1,697	$1,045	$1,751

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA01

New Plan Number	Plan	Single Premium Rate 3Q 2014	Parent & Child(ren) Premium Rate 3Q 2014	Couple Premium Rate 3Q 2014	Family Premium Rate 3Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 3Q 2014	With dependent up to age 30 rider: Family Premium Rate 3Q 2014
14018887	EPO	$414	$704	$829	$1,181	$727	$1,218
14018888	EPO	$406	$690	$811	$1,156	$712	$1,193
14018889	EPO	$385	$654	$770	$1,097	$675	$1,132
14018892	EPO	$419	$712	$838	$1,194	$735	$1,232
14018894	EPO	$409	$695	$817	$1,165	$717	$1,202
14018893	EPO	$405	$689	$810	$1,155	$711	$1,192
14018886	EPO	$490	$833	$979	$1,396	$859	$1,440
14018884	EPO	$533	$906	$1,065	$1,518	$935	$1,567
14018885	EPO	$568	$965	$1,135	$1,618	$996	$1,669
14018890	MC	$568	$966	$1,136	$1,619	$996	$1,670
14018895	MC	$540	$918	$1,080	$1,539	$947	$1,588
14018891	EPO	$518	$880	$1,035	$1,475	$908	$1,522
14018896	Indemnity	$704	$1,197	$1,408	$2,006	$1,235	$2,070
14018883	EPO	$620	$1,053	$1,239	$1,766	$1,087	$1,822
14018901	EPO	$411	$699	$823	$1,172	$722	$1,210
14018902	EPO	$403	$685	$806	$1,148	$707	$1,185
14018903	EPO	$382	$650	$765	$1,089	$671	$1,124
14018904	EPO	$416	$707	$832	$1,186	$730	$1,224
14018906	EPO	$406	$690	$812	$1,157	$712	$1,194
14018907	EPO	$402	$684	$805	$1,147	$706	$1,183
14018900	EPO	$482	$820	$965	$1,375	$846	$1,419
14018899	EPO	$525	$892	$1,050	$1,496	$921	$1,544
14018898	EPO	$559	$951	$1,118	$1,594	$981	$1,645
14018912	MC	$560	$951	$1,119	$1,595	$982	$1,646
14018913	MC	$532	$904	$1,064	$1,516	$933	$1,565
14018905	EPO	$510	$867	$1,020	$1,453	$895	$1,500
14018908	Indemnity	$693	$1,179	$1,387	$1,976	$1,217	$2,040
14018897	EPO	$610	$1,038	$1,221	$1,740	$1,071	$1,795

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA01

New Plan Number	Plan	Single Premium Rate 4Q 2014	Parent & Child(ren) Premium Rate 4Q 2014	Couple Premium Rate 4Q 2014	Family Premium Rate 4Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 4Q 2014	With dependent up to age 30 rider: Family Premium Rate 4Q 2014
14018887	EPO	$425	$722	$849	$1,210	$745	$1,249
14018888	EPO	$416	$707	$832	$1,185	$730	$1,223
14018889	EPO	$395	$671	$789	$1,125	$692	$1,161
14018892	EPO	$430	$730	$859	$1,224	$754	$1,263
14018894	EPO	$419	$712	$838	$1,194	$735	$1,232
14018893	EPO	$415	$706	$831	$1,184	$729	$1,222
14018886	EPO	$502	$854	$1,004	$1,431	$881	$1,477
14018884	EPO	$546	$928	$1,092	$1,557	$958	$1,606
14018885	EPO	$582	$989	$1,164	$1,658	$1,021	$1,711
14018890	MC	$582	$990	$1,165	$1,660	$1,022	$1,713
14018895	MC	$554	$941	$1,107	$1,578	$971	$1,628
14018891	EPO	$531	$902	$1,061	$1,512	$931	$1,561
14018896	Indemnity	$722	$1,227	$1,443	$2,057	$1,266	$2,122
14018883	EPO	$635	$1,080	$1,270	$1,810	$1,114	$1,868
14018901	EPO	$422	$717	$844	$1,202	$740	$1,241
14018902	EPO	$413	$702	$826	$1,177	$725	$1,215
14018903	EPO	$392	$666	$784	$1,117	$688	$1,153
14018904	EPO	$427	$725	$853	$1,216	$748	$1,255
14018906	EPO	$416	$707	$832	$1,186	$730	$1,224
14018907	EPO	$413	$701	$825	$1,176	$724	$1,213
14018900	EPO	$495	$841	$989	$1,410	$868	$1,455
14018899	EPO	$538	$915	$1,076	$1,534	$944	$1,583
14018898	EPO	$573	$975	$1,147	$1,634	$1,006	$1,686
14018912	MC	$574	$975	$1,147	$1,635	$1,006	$1,687
14018913	MC	$545	$927	$1,091	$1,555	$957	$1,604
14018905	EPO	$523	$889	$1,046	$1,490	$917	$1,538
14018908	Indemnity	$711	$1,209	$1,422	$2,026	$1,247	$2,091
14018897	EPO	$626	$1,064	$1,252	$1,784	$1,098	$1,841

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA02

New Plan Number	Plan	Single Premium Rate 1Q 2014	Parent & Child(ren) Premium Rate 1Q 2014	Couple Premium Rate 1Q 2014	Family Premium Rate 1Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 1Q 2014	With dependent up to age 30 rider: Family Premium Rate 1Q 2014
14018887	EPO	$463	$787	$926	$1,319	$812	$1,361
14018888	EPO	$453	$770	$906	$1,292	$795	$1,333
14018889	EPO	$430	$731	$860	$1,226	$755	$1,265
14018892	EPO	$468	$796	$936	$1,334	$821	$1,377
14018894	EPO	$457	$776	$913	$1,301	$801	$1,343
14018893	EPO	$453	$770	$905	$1,290	$794	$1,332
14018886	EPO	$547	$930	$1,094	$1,559	$960	$1,609
14018884	EPO	$595	$1,012	$1,190	$1,696	$1,044	$1,750
14018885	EPO	$634	$1,078	$1,268	$1,807	$1,112	$1,865
14018890	MC	$635	$1,079	$1,269	$1,808	$1,113	$1,866
14018895	MC	$603	$1,026	$1,207	$1,719	$1,058	$1,774
14018891	EPO	$578	$983	$1,156	$1,648	$1,014	$1,701
14018896	Indemnity	$786	$1,337	$1,573	$2,241	$1,380	$2,313
14018883	EPO	$692	$1,177	$1,384	$1,973	$1,214	$2,036
14018901	EPO	$460	$781	$919	$1,310	$806	$1,352
14018902	EPO	$450	$765	$900	$1,283	$790	$1,324
14018903	EPO	$427	$726	$854	$1,217	$749	$1,256
14018904	EPO	$465	$790	$930	$1,325	$815	$1,367
14018906	EPO	$453	$771	$907	$1,292	$795	$1,333
14018907	EPO	$450	$764	$899	$1,281	$789	$1,322
14018900	EPO	$539	$916	$1,078	$1,536	$946	$1,585
14018899	EPO	$586	$997	$1,173	$1,671	$1,029	$1,725
14018898	EPO	$625	$1,062	$1,249	$1,780	$1,096	$1,837
14018912	MC	$625	$1,063	$1,250	$1,782	$1,097	$1,839
14018913	MC	$594	$1,010	$1,189	$1,694	$1,043	$1,748
14018905	EPO	$570	$968	$1,139	$1,623	$999	$1,675
14018908	Indemnity	$775	$1,317	$1,549	$2,208	$1,359	$2,279
14018897	EPO	$682	$1,159	$1,364	$1,944	$1,196	$2,006

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA02

New Plan Number	Plan	Single Premium Rate 2Q 2014	Parent & Child(ren) Premium Rate 2Q 2014	Couple Premium Rate 2Q 2014	Family Premium Rate 2Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 2Q 2014	With dependent up to age 30 rider: Family Premium Rate 2Q 2014
14018887	EPO	$474	$807	$949	$1,352	$832	$1,396
14018888	EPO	$465	$790	$929	$1,324	$815	$1,366
14018889	EPO	$441	$750	$882	$1,257	$773	$1,297
14018892	EPO	$480	$816	$960	$1,368	$842	$1,411
14018894	EPO	$468	$796	$936	$1,334	$821	$1,377
14018893	EPO	$464	$789	$928	$1,323	$814	$1,365
14018886	EPO	$561	$954	$1,122	$1,599	$984	$1,650
14018884	EPO	$610	$1,037	$1,220	$1,739	$1,070	$1,794
14018885	EPO	$650	$1,105	$1,300	$1,853	$1,140	$1,912
14018890	MC	$650	$1,106	$1,301	$1,854	$1,141	$1,913
14018895	MC	$618	$1,051	$1,237	$1,763	$1,085	$1,819
14018891	EPO	$593	$1,008	$1,185	$1,689	$1,040	$1,743
14018896	Indemnity	$806	$1,370	$1,612	$2,297	$1,414	$2,371
14018883	EPO	$710	$1,206	$1,419	$2,022	$1,245	$2,087
14018901	EPO	$471	$801	$942	$1,343	$827	$1,386
14018902	EPO	$461	$784	$923	$1,315	$809	$1,357
14018903	EPO	$438	$744	$876	$1,248	$768	$1,288
14018904	EPO	$476	$810	$953	$1,358	$836	$1,401
14018906	EPO	$465	$790	$930	$1,325	$815	$1,367
14018907	EPO	$461	$783	$922	$1,313	$809	$1,355
14018900	EPO	$553	$939	$1,105	$1,575	$969	$1,625
14018899	EPO	$601	$1,022	$1,202	$1,713	$1,055	$1,768
14018898	EPO	$640	$1,089	$1,281	$1,825	$1,124	$1,884
14018912	MC	$641	$1,089	$1,282	$1,827	$1,124	$1,885
14018913	MC	$609	$1,036	$1,219	$1,737	$1,069	$1,792
14018905	EPO	$584	$993	$1,168	$1,664	$1,025	$1,718
14018908	Indemnity	$794	$1,350	$1,588	$2,264	$1,393	$2,336
14018897	EPO	$699	$1,188	$1,398	$1,992	$1,226	$2,056

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA02

New Plan Number	Plan	Single Premium Rate 3Q 2014	Parent & Child(ren) Premium Rate 3Q 2014	Couple Premium Rate 3Q 2014	Family Premium Rate 3Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 3Q 2014	With dependent up to age 30 rider: Family Premium Rate 3Q 2014
14018887	EPO	$486	$827	$973	$1,386	$853	$1,431
14018888	EPO	$476	$810	$953	$1,357	$836	$1,401
14018889	EPO	$452	$768	$904	$1,288	$793	$1,329
14018892	EPO	$492	$836	$984	$1,402	$863	$1,447
14018894	EPO	$480	$816	$960	$1,367	$842	$1,411
14018893	EPO	$476	$809	$952	$1,356	$835	$1,399
14018886	EPO	$575	$978	$1,150	$1,639	$1,009	$1,691
14018884	EPO	$626	$1,063	$1,251	$1,783	$1,097	$1,840
14018885	EPO	$666	$1,133	$1,333	$1,899	$1,169	$1,960
14018890	MC	$667	$1,134	$1,334	$1,901	$1,170	$1,961
14018895	MC	$634	$1,078	$1,268	$1,807	$1,112	$1,865
14018891	EPO	$608	$1,033	$1,215	$1,732	$1,066	$1,787
14018896	Indemnity	$826	$1,405	$1,653	$2,355	$1,450	$2,431
14018883	EPO	$727	$1,237	$1,455	$2,073	$1,276	$2,140
14018901	EPO	$483	$821	$966	$1,377	$847	$1,421
14018902	EPO	$473	$804	$946	$1,348	$830	$1,391
14018903	EPO	$449	$763	$898	$1,279	$787	$1,320
14018904	EPO	$489	$830	$977	$1,392	$857	$1,437
14018906	EPO	$476	$810	$953	$1,358	$836	$1,401
14018907	EPO	$472	$803	$945	$1,347	$829	$1,390
14018900	EPO	$567	$963	$1,133	$1,615	$994	$1,666
14018899	EPO	$616	$1,048	$1,233	$1,756	$1,081	$1,813
14018898	EPO	$657	$1,116	$1,313	$1,871	$1,152	$1,931
14018912	MC	$657	$1,117	$1,314	$1,873	$1,153	$1,932
14018913	MC	$625	$1,062	$1,249	$1,780	$1,096	$1,837
14018905	EPO	$599	$1,018	$1,197	$1,706	$1,050	$1,761
14018908	Indemnity	$814	$1,384	$1,628	$2,321	$1,429	$2,395
14018897	EPO	$717	$1,218	$1,433	$2,043	$1,257	$2,108

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA02

New Plan Number	Plan	Single Premium Rate 4Q 2014	Parent & Child(ren) Premium Rate 4Q 2014	Couple Premium Rate 4Q 2014	Family Premium Rate 4Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 4Q 2014	With dependent up to age 30 rider: Family Premium Rate 4Q 2014
14018887	EPO	$499	$848	$997	$1,421	$875	$1,467
14018888	EPO	$488	$830	$977	$1,392	$857	$1,436
14018889	EPO	$463	$788	$927	$1,321	$813	$1,363
14018892	EPO	$504	$857	$1,009	$1,437	$885	$1,483
14018894	EPO	$492	$836	$984	$1,402	$863	$1,447
14018893	EPO	$488	$829	$976	$1,390	$856	$1,435
14018886	EPO	$590	$1,002	$1,179	$1,680	$1,034	$1,734
14018884	EPO	$641	$1,090	$1,283	$1,828	$1,125	$1,886
14018885	EPO	$683	$1,162	$1,367	$1,947	$1,199	$2,010
14018890	MC	$684	$1,162	$1,367	$1,949	$1,200	$2,011
14018895	MC	$650	$1,105	$1,300	$1,853	$1,141	$1,912
14018891	EPO	$623	$1,059	$1,246	$1,776	$1,093	$1,832
14018896	Indemnity	$847	$1,440	$1,695	$2,415	$1,487	$2,492
14018883	EPO	$746	$1,268	$1,492	$2,126	$1,308	$2,194
14018901	EPO	$495	$842	$991	$1,411	$869	$1,457
14018902	EPO	$485	$824	$970	$1,382	$851	$1,426
14018903	EPO	$460	$782	$920	$1,312	$807	$1,354
14018904	EPO	$501	$851	$1,002	$1,427	$879	$1,473
14018906	EPO	$489	$830	$977	$1,392	$857	$1,437
14018907	EPO	$484	$824	$969	$1,381	$850	$1,425
14018900	EPO	$581	$987	$1,162	$1,655	$1,019	$1,708
14018899	EPO	$632	$1,074	$1,264	$1,801	$1,108	$1,858
14018898	EPO	$673	$1,144	$1,346	$1,919	$1,181	$1,980
14018912	MC	$674	$1,145	$1,347	$1,920	$1,182	$1,981
14018913	MC	$640	$1,089	$1,281	$1,825	$1,124	$1,884
14018905	EPO	$614	$1,043	$1,228	$1,749	$1,077	$1,805
14018908	Indemnity	$835	$1,419	$1,670	$2,379	$1,465	$2,455
14018897	EPO	$735	$1,249	$1,470	$2,094	$1,289	$2,161

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA03

New Plan Number	Plan	Single Premium Rate 1Q 2014	Parent & Child(ren) Premium Rate 1Q 2014	Couple Premium Rate 1Q 2014	Family Premium Rate 1Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 1Q 2014	With dependent up to age 30 rider: Family Premium Rate 1Q 2014
14018887	EPO	$338	$575	$677	$965	$594	$995
14018888	EPO	$331	$563	$663	$944	$581	$975
14018889	EPO	$314	$535	$629	$896	$552	$925
14018892	EPO	$342	$582	$685	$975	$600	$1,007
14018894	EPO	$334	$568	$668	$951	$586	$982
14018893	EPO	$331	$563	$662	$943	$581	$974
14018886	EPO	$400	$680	$800	$1,140	$702	$1,177
14018884	EPO	$435	$740	$870	$1,240	$763	$1,280
14018885	EPO	$464	$788	$927	$1,321	$813	$1,364
14018890	MC	$464	$789	$928	$1,322	$814	$1,365
14018895	MC	$441	$750	$882	$1,257	$774	$1,297
14018891	EPO	$423	$719	$846	$1,205	$742	$1,243
14018896	Indemnity	$575	$977	$1,150	$1,639	$1,009	$1,691
14018883	EPO	$506	$860	$1,012	$1,442	$888	$1,489
14018901	EPO	$336	$571	$672	$958	$590	$988
14018902	EPO	$329	$559	$658	$938	$577	$968
14018903	EPO	$312	$531	$625	$890	$548	$919
14018904	EPO	$340	$578	$680	$969	$596	$1,000
14018906	EPO	$332	$564	$663	$945	$582	$975
14018907	EPO	$329	$559	$657	$937	$577	$967
14018900	EPO	$394	$670	$788	$1,123	$692	$1,159
14018899	EPO	$429	$729	$858	$1,222	$752	$1,261
14018898	EPO	$457	$777	$914	$1,302	$801	$1,344
14018912	MC	$457	$777	$914	$1,303	$802	$1,344
14018913	MC	$435	$739	$869	$1,239	$763	$1,278
14018905	EPO	$417	$708	$833	$1,187	$731	$1,225
14018908	Indemnity	$566	$963	$1,133	$1,615	$994	$1,666
14018897	EPO	$499	$848	$997	$1,421	$875	$1,467

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA03

New Plan Number	Plan	Single Premium Rate 2Q 2014	Parent & Child(ren) Premium Rate 2Q 2014	Couple Premium Rate 2Q 2014	Family Premium Rate 2Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 2Q 2014	With dependent up to age 30 rider: Family Premium Rate 2Q 2014
14018887	EPO	$347	$590	$694	$989	$609	$1,020
14018888	EPO	$340	$577	$679	$968	$596	$999
14018889	EPO	$322	$548	$645	$919	$566	$948
14018892	EPO	$351	$596	$702	$1,000	$616	$1,032
14018894	EPO	$342	$582	$684	$975	$600	$1,007
14018893	EPO	$339	$577	$679	$967	$595	$998
14018886	EPO	$410	$697	$820	$1,169	$720	$1,206
14018884	EPO	$446	$758	$892	$1,271	$783	$1,312
14018885	EPO	$475	$808	$951	$1,355	$834	$1,398
14018890	MC	$476	$809	$951	$1,356	$834	$1,399
14018895	MC	$452	$769	$904	$1,289	$793	$1,330
14018891	EPO	$433	$737	$867	$1,235	$760	$1,275
14018896	Indemnity	$589	$1,002	$1,179	$1,680	$1,034	$1,734
14018883	EPO	$519	$882	$1,038	$1,479	$910	$1,526
14018901	EPO	$345	$586	$689	$982	$604	$1,013
14018902	EPO	$337	$573	$675	$961	$592	$992
14018903	EPO	$320	$544	$640	$912	$562	$942
14018904	EPO	$348	$592	$697	$993	$611	$1,025
14018906	EPO	$340	$578	$680	$969	$596	$1,000
14018907	EPO	$337	$573	$674	$960	$591	$991
14018900	EPO	$404	$687	$808	$1,152	$709	$1,188
14018899	EPO	$440	$747	$879	$1,253	$771	$1,293
14018898	EPO	$468	$796	$937	$1,335	$822	$1,377
14018912	MC	$469	$797	$937	$1,336	$822	$1,378
14018913	MC	$446	$757	$891	$1,270	$782	$1,310
14018905	EPO	$427	$726	$854	$1,217	$749	$1,256
14018908	Indemnity	$581	$987	$1,161	$1,655	$1,019	$1,708
14018897	EPO	$511	$869	$1,022	$1,457	$897	$1,503

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA03

New Plan Number	Plan	Single Premium Rate 3Q 2014	Parent & Child(ren) Premium Rate 3Q 2014	Couple Premium Rate 3Q 2014	Family Premium Rate 3Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 3Q 2014	With dependent up to age 30 rider: Family Premium Rate 3Q 2014
14018887	EPO	$356	$605	$711	$1,014	$624	$1,046
14018888	EPO	$348	$592	$697	$993	$611	$1,024
14018889	EPO	$331	$562	$661	$942	$580	$972
14018892	EPO	$360	$611	$719	$1,025	$631	$1,058
14018894	EPO	$351	$596	$702	$1,000	$616	$1,032
14018893	EPO	$348	$591	$696	$992	$610	$1,023
14018886	EPO	$420	$715	$841	$1,198	$738	$1,237
14018884	EPO	$457	$778	$915	$1,304	$802	$1,345
14018885	EPO	$487	$828	$975	$1,389	$855	$1,433
14018890	MC	$488	$829	$975	$1,390	$856	$1,434
14018895	MC	$464	$788	$927	$1,321	$813	$1,364
14018891	EPO	$444	$755	$889	$1,266	$780	$1,307
14018896	Indemnity	$604	$1,027	$1,209	$1,722	$1,060	$1,777
14018883	EPO	$532	$904	$1,064	$1,516	$933	$1,564
14018901	EPO	$353	$600	$706	$1,007	$620	$1,039
14018902	EPO	$346	$588	$692	$986	$607	$1,017
14018903	EPO	$328	$558	$656	$935	$576	$965
14018904	EPO	$357	$607	$714	$1,018	$627	$1,051
14018906	EPO	$348	$592	$697	$993	$611	$1,025
14018907	EPO	$345	$587	$691	$985	$606	$1,016
14018900	EPO	$414	$704	$829	$1,181	$727	$1,218
14018899	EPO	$451	$766	$901	$1,284	$791	$1,325
14018898	EPO	$480	$816	$960	$1,368	$842	$1,412
14018912	MC	$480	$817	$961	$1,369	$843	$1,413
14018913	MC	$457	$777	$914	$1,302	$801	$1,343
14018905	EPO	$438	$744	$876	$1,248	$768	$1,288
14018908	Indemnity	$595	$1,012	$1,191	$1,697	$1,045	$1,751
14018897	EPO	$524	$891	$1,048	$1,494	$919	$1,541

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA03

New Plan Number	Plan	Single Premium Rate 4Q 2014	Parent & Child(ren) Premium Rate 4Q 2014	Couple Premium Rate 4Q 2014	Family Premium Rate 4Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 4Q 2014	With dependent up to age 30 rider: Family Premium Rate 4Q 2014
14018887	EPO	$365	$620	$729	$1,039	$640	$1,073
14018888	EPO	$357	$607	$714	$1,018	$626	$1,050
14018889	EPO	$339	$576	$678	$966	$594	$997
14018892	EPO	$369	$627	$738	$1,051	$647	$1,085
14018894	EPO	$360	$612	$719	$1,025	$631	$1,058
14018893	EPO	$357	$606	$713	$1,017	$626	$1,049
14018886	EPO	$431	$733	$862	$1,229	$756	$1,268
14018884	EPO	$469	$797	$938	$1,336	$823	$1,379
14018885	EPO	$500	$849	$999	$1,424	$877	$1,469
14018890	MC	$500	$850	$1,000	$1,425	$877	$1,470
14018895	MC	$475	$808	$951	$1,355	$834	$1,398
14018891	EPO	$456	$774	$911	$1,298	$799	$1,340
14018896	Indemnity	$620	$1,053	$1,239	$1,766	$1,087	$1,822
14018883	EPO	$545	$927	$1,091	$1,554	$957	$1,604
14018901	EPO	$362	$616	$724	$1,032	$635	$1,065
14018902	EPO	$355	$603	$709	$1,011	$622	$1,043
14018903	EPO	$337	$572	$673	$959	$590	$990
14018904	EPO	$366	$623	$732	$1,044	$643	$1,077
14018906	EPO	$357	$607	$714	$1,018	$627	$1,051
14018907	EPO	$354	$602	$708	$1,010	$621	$1,042
14018900	EPO	$425	$722	$849	$1,210	$745	$1,249
14018899	EPO	$462	$785	$924	$1,317	$811	$1,359
14018898	EPO	$492	$837	$984	$1,403	$864	$1,448
14018912	MC	$493	$837	$985	$1,404	$864	$1,449
14018913	MC	$468	$796	$937	$1,335	$822	$1,377
14018905	EPO	$449	$763	$898	$1,279	$787	$1,320
14018908	Indemnity	$610	$1,038	$1,221	$1,740	$1,071	$1,795
14018897	EPO	$537	$913	$1,075	$1,531	$943	$1,580

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA04

New Plan Number	Plan	Single Premium Rate 1Q 2014	Parent & Child(ren) Premium Rate 1Q 2014	Couple Premium Rate 1Q 2014	Family Premium Rate 1Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 1Q 2014	With dependent up to age 30 rider: Family Premium Rate 1Q 2014
14018887	EPO	$387	$657	$773	$1,102	$678	$1,137
14018888	EPO	$379	$643	$757	$1,079	$664	$1,113
14018889	EPO	$359	$611	$718	$1,024	$630	$1,057
14018892	EPO	$391	$665	$782	$1,114	$686	$1,150
14018894	EPO	$381	$648	$763	$1,087	$669	$1,122
14018893	EPO	$378	$643	$756	$1,078	$663	$1,112
14018886	EPO	$457	$777	$914	$1,302	$802	$1,344
14018884	EPO	$497	$845	$994	$1,417	$872	$1,462
14018885	EPO	$530	$900	$1,059	$1,509	$929	$1,558
14018890	MC	$530	$901	$1,060	$1,511	$930	$1,559
14018895	MC	$504	$857	$1,008	$1,436	$884	$1,482
14018891	EPO	$483	$821	$966	$1,376	$847	$1,420
14018896	Indemnity	$657	$1,117	$1,314	$1,872	$1,152	$1,932
14018883	EPO	$578	$983	$1,156	$1,648	$1,014	$1,700
14018901	EPO	$384	$653	$768	$1,094	$674	$1,129
14018902	EPO	$376	$639	$752	$1,071	$659	$1,106
14018903	EPO	$357	$606	$713	$1,017	$626	$1,049
14018904	EPO	$388	$660	$776	$1,106	$681	$1,142
14018906	EPO	$379	$644	$757	$1,079	$664	$1,114
14018907	EPO	$375	$638	$751	$1,070	$659	$1,104
14018900	EPO	$450	$765	$901	$1,283	$790	$1,324
14018899	EPO	$490	$833	$980	$1,396	$859	$1,441
14018898	EPO	$522	$887	$1,044	$1,487	$915	$1,535
14018912	MC	$522	$888	$1,044	$1,488	$916	$1,536
14018913	MC	$496	$844	$993	$1,415	$871	$1,460
14018905	EPO	$476	$809	$952	$1,356	$835	$1,399
14018908	Indemnity	$647	$1,100	$1,294	$1,844	$1,135	$1,903
14018897	EPO	$570	$968	$1,139	$1,623	$999	$1,675

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA04

New Plan Number	Plan	Single Premium Rate 2Q 2014	Parent & Child(ren) Premium Rate 2Q 2014	Couple Premium Rate 2Q 2014	Family Premium Rate 2Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 2Q 2014	With dependent up to age 30 rider: Family Premium Rate 2Q 2014
14018887	EPO	$396	$674	$793	$1,129	$695	$1,166
14018888	EPO	$388	$660	$776	$1,106	$681	$1,141
14018889	EPO	$368	$626	$737	$1,050	$646	$1,083
14018892	EPO	$401	$681	$802	$1,142	$703	$1,179
14018894	EPO	$391	$665	$782	$1,114	$686	$1,150
14018893	EPO	$388	$659	$775	$1,105	$680	$1,140
14018886	EPO	$468	$796	$937	$1,335	$822	$1,378
14018884	EPO	$510	$866	$1,019	$1,452	$894	$1,499
14018885	EPO	$543	$923	$1,086	$1,547	$953	$1,597
14018890	MC	$543	$924	$1,087	$1,548	$953	$1,598
14018895	MC	$517	$878	$1,033	$1,472	$906	$1,519
14018891	EPO	$495	$842	$990	$1,411	$869	$1,456
14018896	Indemnity	$673	$1,145	$1,347	$1,919	$1,181	$1,980
14018883	EPO	$593	$1,008	$1,185	$1,689	$1,040	$1,743
14018901	EPO	$394	$669	$787	$1,122	$690	$1,158
14018902	EPO	$385	$655	$771	$1,098	$676	$1,133
14018903	EPO	$366	$622	$731	$1,042	$642	$1,076
14018904	EPO	$398	$677	$796	$1,134	$698	$1,171
14018906	EPO	$388	$660	$776	$1,106	$681	$1,142
14018907	EPO	$385	$654	$770	$1,097	$675	$1,132
14018900	EPO	$462	$785	$923	$1,315	$810	$1,358
14018899	EPO	$502	$854	$1,004	$1,431	$881	$1,477
14018898	EPO	$535	$909	$1,070	$1,525	$938	$1,573
14018912	MC	$535	$910	$1,071	$1,526	$939	$1,574
14018913	MC	$509	$865	$1,018	$1,451	$893	$1,497
14018905	EPO	$488	$829	$976	$1,390	$856	$1,435
14018908	Indemnity	$663	$1,128	$1,327	$1,891	$1,164	$1,951
14018897	EPO	$584	$993	$1,168	$1,664	$1,024	$1,717

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA04

New Plan Number	Plan	Single Premium Rate 3Q 2014	Parent & Child(ren) Premium Rate 3Q 2014	Couple Premium Rate 3Q 2014	Family Premium Rate 3Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 3Q 2014	With dependent up to age 30 rider: Family Premium Rate 3Q 2014
14018887	EPO	$406	$691	$813	$1,158	$713	$1,195
14018888	EPO	$398	$676	$796	$1,134	$698	$1,170
14018889	EPO	$378	$642	$755	$1,076	$662	$1,110
14018892	EPO	$411	$699	$822	$1,171	$721	$1,209
14018894	EPO	$401	$681	$802	$1,142	$703	$1,179
14018893	EPO	$397	$676	$795	$1,133	$697	$1,169
14018886	EPO	$480	$817	$961	$1,369	$843	$1,413
14018884	EPO	$522	$888	$1,045	$1,489	$917	$1,537
14018885	EPO	$557	$946	$1,113	$1,586	$977	$1,637
14018890	MC	$557	$947	$1,114	$1,588	$977	$1,638
14018895	MC	$530	$900	$1,059	$1,509	$929	$1,558
14018891	EPO	$508	$863	$1,015	$1,447	$890	$1,493
14018896	Indemnity	$690	$1,174	$1,381	$1,967	$1,211	$2,030
14018883	EPO	$608	$1,033	$1,215	$1,732	$1,066	$1,787
14018901	EPO	$403	$686	$807	$1,150	$708	$1,187
14018902	EPO	$395	$672	$790	$1,126	$693	$1,162
14018903	EPO	$375	$637	$750	$1,069	$658	$1,103
14018904	EPO	$408	$694	$816	$1,163	$716	$1,200
14018906	EPO	$398	$677	$796	$1,134	$698	$1,171
14018907	EPO	$395	$671	$789	$1,125	$692	$1,161
14018900	EPO	$473	$804	$946	$1,349	$830	$1,392
14018899	EPO	$515	$875	$1,029	$1,467	$903	$1,514
14018898	EPO	$548	$932	$1,097	$1,563	$962	$1,613
14018912	MC	$549	$933	$1,098	$1,564	$963	$1,614
14018913	MC	$522	$887	$1,044	$1,487	$915	$1,535
14018905	EPO	$500	$850	$1,000	$1,425	$877	$1,471
14018908	Indemnity	$680	$1,156	$1,360	$1,938	$1,193	$2,000
14018897	EPO	$599	$1,018	$1,197	$1,706	$1,050	$1,761

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA04

New Plan Number	Plan	Single Premium Rate 4Q 2014	Parent & Child(ren) Premium Rate 4Q 2014	Couple Premium Rate 4Q 2014	Family Premium Rate 4Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 4Q 2014	With dependent up to age 30 rider: Family Premium Rate 4Q 2014
14018887	EPO	$417	$708	$833	$1,187	$731	$1,225
14018888	EPO	$408	$693	$816	$1,162	$716	$1,200
14018889	EPO	$387	$658	$774	$1,103	$679	$1,138
14018892	EPO	$421	$716	$843	$1,201	$739	$1,239
14018894	EPO	$411	$699	$822	$1,171	$721	$1,209
14018893	EPO	$407	$693	$815	$1,161	$715	$1,198
14018886	EPO	$492	$837	$985	$1,403	$864	$1,448
14018884	EPO	$536	$911	$1,071	$1,527	$940	$1,575
14018885	EPO	$571	$970	$1,141	$1,627	$1,001	$1,679
14018890	MC	$571	$971	$1,142	$1,628	$1,002	$1,680
14018895	MC	$543	$923	$1,086	$1,548	$953	$1,597
14018891	EPO	$520	$885	$1,041	$1,483	$913	$1,531
14018896	Indemnity	$708	$1,203	$1,415	$2,017	$1,242	$2,082
14018883	EPO	$623	$1,059	$1,246	$1,775	$1,093	$1,832
14018901	EPO	$414	$703	$827	$1,179	$726	$1,217
14018902	EPO	$405	$689	$810	$1,154	$711	$1,191
14018903	EPO	$384	$653	$769	$1,096	$674	$1,131
14018904	EPO	$418	$711	$837	$1,192	$734	$1,230
14018906	EPO	$408	$694	$816	$1,163	$716	$1,200
14018907	EPO	$405	$688	$809	$1,153	$710	$1,190
14018900	EPO	$485	$825	$970	$1,383	$851	$1,427
14018899	EPO	$528	$897	$1,055	$1,504	$926	$1,552
14018898	EPO	$562	$956	$1,125	$1,602	$986	$1,654
14018912	MC	$563	$957	$1,125	$1,604	$987	$1,655
14018913	MC	$535	$909	$1,070	$1,525	$939	$1,573
14018905	EPO	$513	$872	$1,025	$1,461	$899	$1,508
14018908	Indemnity	$697	$1,185	$1,395	$1,987	$1,223	$2,051
14018897	EPO	$614	$1,043	$1,228	$1,749	$1,077	$1,805

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA05

New Plan Number	Plan	Single Premium Rate 1Q 2014	Parent & Child(ren) Premium Rate 1Q 2014	Couple Premium Rate 1Q 2014	Family Premium Rate 1Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 1Q 2014	With dependent up to age 30 rider: Family Premium Rate 1Q 2014
14018887	EPO	$335	$570	$670	$955	$588	$986
14018888	EPO	$328	$558	$656	$935	$576	$965
14018889	EPO	$311	$529	$623	$888	$546	$916
14018892	EPO	$339	$576	$678	$966	$595	$997
14018894	EPO	$331	$562	$661	$942	$580	$972
14018893	EPO	$328	$557	$656	$934	$575	$964
14018886	EPO	$396	$674	$792	$1,129	$695	$1,165
14018884	EPO	$431	$733	$862	$1,228	$756	$1,268
14018885	EPO	$459	$781	$918	$1,309	$806	$1,351
14018890	MC	$459	$781	$919	$1,310	$806	$1,351
14018895	MC	$437	$743	$874	$1,245	$766	$1,285
14018891	EPO	$419	$712	$837	$1,193	$735	$1,231
14018896	Indemnity	$569	$968	$1,139	$1,623	$999	$1,675
14018883	EPO	$501	$852	$1,002	$1,428	$879	$1,474
14018901	EPO	$333	$566	$666	$949	$584	$979
14018902	EPO	$326	$554	$652	$929	$572	$958
14018903	EPO	$309	$526	$619	$881	$543	$910
14018904	EPO	$337	$572	$673	$959	$591	$990
14018906	EPO	$328	$558	$657	$936	$576	$966
14018907	EPO	$326	$553	$651	$928	$571	$957
14018900	EPO	$390	$664	$781	$1,113	$685	$1,148
14018899	EPO	$425	$722	$849	$1,210	$745	$1,249
14018898	EPO	$452	$769	$905	$1,289	$794	$1,331
14018912	MC	$453	$770	$905	$1,290	$794	$1,331
14018913	MC	$430	$732	$861	$1,227	$755	$1,266
14018905	EPO	$413	$701	$825	$1,176	$724	$1,213
14018908	Indemnity	$561	$954	$1,122	$1,599	$984	$1,650
14018897	EPO	$494	$839	$988	$1,407	$866	$1,452

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA05

New Plan Number	Plan	Single Premium Rate 2Q 2014	Parent & Child(ren) Premium Rate 2Q 2014	Couple Premium Rate 2Q 2014	Family Premium Rate 2Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 2Q 2014	With dependent up to age 30 rider: Family Premium Rate 2Q 2014
14018887	EPO	$344	$584	$687	$979	$603	$1,011
14018888	EPO	$336	$572	$673	$959	$590	$989
14018889	EPO	$319	$543	$639	$910	$560	$939
14018892	EPO	$347	$591	$695	$990	$610	$1,022
14018894	EPO	$339	$576	$678	$966	$595	$997
14018893	EPO	$336	$571	$672	$958	$590	$988
14018886	EPO	$406	$690	$812	$1,158	$713	$1,195
14018884	EPO	$442	$751	$884	$1,259	$775	$1,299
14018885	EPO	$471	$800	$941	$1,342	$826	$1,384
14018890	MC	$471	$801	$942	$1,342	$826	$1,385
14018895	MC	$448	$761	$896	$1,276	$786	$1,317
14018891	EPO	$429	$730	$858	$1,223	$753	$1,262
14018896	Indemnity	$584	$992	$1,168	$1,664	$1,024	$1,717
14018883	EPO	$514	$873	$1,028	$1,464	$901	$1,511
14018901	EPO	$341	$580	$682	$972	$599	$1,004
14018902	EPO	$334	$568	$668	$952	$586	$983
14018903	EPO	$317	$539	$634	$904	$556	$932
14018904	EPO	$345	$587	$690	$983	$605	$1,015
14018906	EPO	$337	$572	$673	$959	$590	$990
14018907	EPO	$334	$567	$667	$951	$585	$982
14018900	EPO	$400	$680	$800	$1,140	$702	$1,177
14018899	EPO	$435	$740	$871	$1,241	$764	$1,280
14018898	EPO	$464	$788	$928	$1,322	$814	$1,364
14018912	MC	$464	$789	$928	$1,323	$814	$1,365
14018913	MC	$441	$750	$882	$1,258	$774	$1,298
14018905	EPO	$423	$719	$846	$1,205	$742	$1,244
14018908	Indemnity	$575	$978	$1,150	$1,639	$1,009	$1,692
14018897	EPO	$506	$861	$1,012	$1,443	$888	$1,489

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA05

New Plan Number	Plan	Single Premium Rate 3Q 2014	Parent & Child(ren) Premium Rate 3Q 2014	Couple Premium Rate 3Q 2014	Family Premium Rate 3Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 3Q 2014	With dependent up to age 30 rider: Family Premium Rate 3Q 2014
14018887	EPO	$352	$599	$704	$1,004	$618	$1,036
14018888	EPO	$345	$586	$690	$983	$605	$1,014
14018889	EPO	$327	$556	$655	$933	$574	$963
14018892	EPO	$356	$606	$712	$1,015	$625	$1,048
14018894	EPO	$347	$591	$695	$990	$610	$1,022
14018893	EPO	$345	$586	$689	$982	$604	$1,013
14018886	EPO	$416	$708	$833	$1,187	$731	$1,225
14018884	EPO	$453	$770	$906	$1,291	$795	$1,332
14018885	EPO	$483	$820	$965	$1,375	$847	$1,419
14018890	MC	$483	$821	$966	$1,376	$847	$1,420
14018895	MC	$459	$781	$918	$1,309	$806	$1,350
14018891	EPO	$440	$748	$880	$1,254	$772	$1,294
14018896	Indemnity	$598	$1,017	$1,197	$1,706	$1,050	$1,760
14018883	EPO	$527	$896	$1,054	$1,501	$924	$1,549
14018901	EPO	$350	$595	$700	$997	$614	$1,029
14018902	EPO	$343	$582	$685	$976	$601	$1,007
14018903	EPO	$325	$553	$650	$926	$570	$956
14018904	EPO	$354	$601	$707	$1,008	$621	$1,040
14018906	EPO	$345	$587	$690	$983	$605	$1,015
14018907	EPO	$342	$582	$684	$975	$600	$1,006
14018900	EPO	$410	$697	$821	$1,169	$720	$1,207
14018899	EPO	$446	$759	$893	$1,272	$783	$1,313
14018898	EPO	$475	$808	$951	$1,355	$834	$1,398
14018912	MC	$476	$809	$952	$1,356	$835	$1,399
14018913	MC	$452	$769	$905	$1,289	$794	$1,331
14018905	EPO	$434	$737	$867	$1,236	$761	$1,275
14018908	Indemnity	$590	$1,002	$1,179	$1,680	$1,034	$1,734
14018897	EPO	$519	$882	$1,038	$1,479	$911	$1,526

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA05

New Plan Number	Plan	Single Premium Rate 4Q 2014	Parent & Child(ren) Premium Rate 4Q 2014	Couple Premium Rate 4Q 2014	Family Premium Rate 4Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 4Q 2014	With dependent up to age 30 rider: Family Premium Rate 4Q 2014
14018887	EPO	$361	$614	$722	$1,029	$634	$1,062
14018888	EPO	$354	$601	$707	$1,008	$620	$1,040
14018889	EPO	$336	$570	$671	$956	$589	$987
14018892	EPO	$365	$621	$730	$1,041	$641	$1,074
14018894	EPO	$356	$606	$712	$1,015	$625	$1,048
14018893	EPO	$353	$601	$706	$1,007	$620	$1,039
14018886	EPO	$427	$726	$854	$1,217	$749	$1,256
14018884	EPO	$464	$789	$929	$1,324	$815	$1,366
14018885	EPO	$495	$841	$990	$1,410	$868	$1,455
14018890	MC	$495	$842	$990	$1,411	$869	$1,456
14018895	MC	$471	$800	$942	$1,342	$826	$1,385
14018891	EPO	$451	$767	$902	$1,286	$792	$1,327
14018896	Indemnity	$614	$1,043	$1,227	$1,749	$1,076	$1,805
14018883	EPO	$540	$918	$1,080	$1,539	$948	$1,589
14018901	EPO	$359	$610	$717	$1,022	$629	$1,055
14018902	EPO	$351	$597	$702	$1,001	$616	$1,033
14018903	EPO	$333	$567	$667	$950	$585	$980
14018904	EPO	$363	$617	$725	$1,034	$636	$1,067
14018906	EPO	$354	$601	$708	$1,008	$621	$1,040
14018907	EPO	$351	$596	$702	$1,000	$615	$1,032
14018900	EPO	$421	$715	$841	$1,199	$738	$1,237
14018899	EPO	$458	$778	$915	$1,304	$803	$1,346
14018898	EPO	$487	$829	$975	$1,389	$855	$1,434
14018912	MC	$488	$829	$976	$1,390	$856	$1,435
14018913	MC	$464	$788	$928	$1,322	$814	$1,364
14018905	EPO	$444	$756	$889	$1,267	$780	$1,307
14018908	Indemnity	$605	$1,028	$1,209	$1,723	$1,061	$1,778
14018897	EPO	$532	$905	$1,064	$1,517	$934	$1,565

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA06

New Plan Number	Plan	Single Premium Rate 1Q 2014	Parent & Child(ren) Premium Rate 1Q 2014	Couple Premium Rate 1Q 2014	Family Premium Rate 1Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 1Q 2014	With dependent up to age 30 rider: Family Premium Rate 1Q 2014
14018887	EPO	$378	$642	$756	$1,077	$663	$1,112
14018888	EPO	$370	$629	$740	$1,055	$649	$1,088
14018889	EPO	$351	$597	$702	$1,001	$616	$1,033
14018892	EPO	$382	$650	$764	$1,089	$671	$1,124
14018894	EPO	$373	$634	$746	$1,062	$654	$1,096
14018893	EPO	$370	$628	$739	$1,054	$649	$1,087
14018886	EPO	$447	$760	$894	$1,273	$784	$1,314
14018884	EPO	$486	$826	$972	$1,385	$853	$1,429
14018885	EPO	$518	$880	$1,036	$1,476	$908	$1,523
14018890	MC	$518	$881	$1,036	$1,477	$909	$1,524
14018895	MC	$493	$837	$985	$1,404	$864	$1,449
14018891	EPO	$472	$803	$944	$1,346	$828	$1,389
14018896	Indemnity	$642	$1,092	$1,284	$1,830	$1,127	$1,889
14018883	EPO	$565	$961	$1,130	$1,611	$992	$1,662
14018901	EPO	$375	$638	$751	$1,070	$658	$1,104
14018902	EPO	$367	$625	$735	$1,047	$645	$1,081
14018903	EPO	$349	$593	$697	$994	$612	$1,026
14018904	EPO	$380	$645	$759	$1,082	$666	$1,116
14018906	EPO	$370	$629	$740	$1,055	$649	$1,089
14018907	EPO	$367	$624	$734	$1,046	$644	$1,080
14018900	EPO	$440	$748	$880	$1,254	$772	$1,295
14018899	EPO	$479	$814	$958	$1,365	$840	$1,408
14018898	EPO	$510	$867	$1,020	$1,454	$895	$1,500
14018912	MC	$510	$868	$1,021	$1,455	$896	$1,501
14018913	MC	$485	$825	$971	$1,383	$852	$1,428
14018905	EPO	$465	$791	$930	$1,326	$816	$1,368
14018908	Indemnity	$633	$1,075	$1,265	$1,803	$1,110	$1,861
14018897	EPO	$557	$947	$1,114	$1,587	$977	$1,638

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA06

New Plan Number	Plan	Single Premium Rate 2Q 2014	Parent & Child(ren) Premium Rate 2Q 2014	Couple Premium Rate 2Q 2014	Family Premium Rate 2Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 2Q 2014	With dependent up to age 30 rider: Family Premium Rate 2Q 2014
14018887	EPO	$387	$659	$775	$1,104	$680	$1,140
14018888	EPO	$379	$645	$759	$1,081	$666	$1,116
14018889	EPO	$360	$612	$720	$1,026	$632	$1,059
14018892	EPO	$392	$666	$784	$1,117	$687	$1,152
14018894	EPO	$382	$650	$764	$1,089	$670	$1,124
14018893	EPO	$379	$644	$758	$1,080	$665	$1,115
14018886	EPO	$458	$779	$916	$1,305	$804	$1,347
14018884	EPO	$498	$847	$996	$1,420	$874	$1,465
14018885	EPO	$531	$902	$1,062	$1,513	$931	$1,561
14018890	MC	$531	$903	$1,062	$1,514	$932	$1,562
14018895	MC	$505	$859	$1,010	$1,439	$886	$1,485
14018891	EPO	$484	$823	$968	$1,379	$849	$1,424
14018896	Indemnity	$658	$1,119	$1,316	$1,876	$1,155	$1,936
14018883	EPO	$579	$985	$1,159	$1,651	$1,016	$1,704
14018901	EPO	$385	$654	$769	$1,096	$675	$1,132
14018902	EPO	$377	$640	$753	$1,074	$661	$1,108
14018903	EPO	$358	$608	$715	$1,019	$627	$1,051
14018904	EPO	$389	$661	$778	$1,109	$683	$1,144
14018906	EPO	$380	$645	$759	$1,082	$666	$1,116
14018907	EPO	$376	$640	$753	$1,073	$660	$1,107
14018900	EPO	$451	$767	$902	$1,286	$792	$1,327
14018899	EPO	$491	$834	$982	$1,399	$861	$1,444
14018898	EPO	$523	$889	$1,046	$1,490	$917	$1,538
14018912	MC	$523	$890	$1,047	$1,491	$918	$1,539
14018913	MC	$498	$846	$995	$1,418	$873	$1,463
14018905	EPO	$477	$811	$954	$1,359	$837	$1,402
14018908	Indemnity	$649	$1,102	$1,297	$1,848	$1,138	$1,907
14018897	EPO	$571	$970	$1,142	$1,627	$1,001	$1,679

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA06

New Plan Number	Plan	Single Premium Rate 3Q 2014	Parent & Child(ren) Premium Rate 3Q 2014	Couple Premium Rate 3Q 2014	Family Premium Rate 3Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 3Q 2014	With dependent up to age 30 rider: Family Premium Rate 3Q 2014
14018887	EPO	$397	$675	$794	$1,132	$697	$1,168
14018888	EPO	$389	$661	$778	$1,108	$682	$1,144
14018889	EPO	$369	$627	$738	$1,052	$648	$1,086
14018892	EPO	$402	$683	$803	$1,145	$705	$1,181
14018894	EPO	$392	$666	$784	$1,117	$687	$1,152
14018893	EPO	$389	$660	$777	$1,107	$682	$1,143
14018886	EPO	$470	$798	$939	$1,338	$824	$1,381
14018884	EPO	$511	$868	$1,022	$1,456	$896	$1,502
14018885	EPO	$544	$925	$1,088	$1,551	$955	$1,601
14018890	MC	$545	$926	$1,089	$1,552	$955	$1,602
14018895	MC	$518	$880	$1,035	$1,476	$908	$1,523
14018891	EPO	$496	$844	$992	$1,414	$871	$1,459
14018896	Indemnity	$675	$1,147	$1,350	$1,923	$1,184	$1,985
14018883	EPO	$594	$1,010	$1,188	$1,693	$1,042	$1,747
14018901	EPO	$394	$671	$789	$1,124	$692	$1,160
14018902	EPO	$386	$657	$772	$1,101	$678	$1,136
14018903	EPO	$367	$623	$733	$1,045	$643	$1,078
14018904	EPO	$399	$678	$798	$1,137	$700	$1,173
14018906	EPO	$389	$661	$778	$1,109	$683	$1,144
14018907	EPO	$386	$656	$772	$1,100	$677	$1,135
14018900	EPO	$463	$786	$925	$1,318	$812	$1,361
14018899	EPO	$503	$855	$1,006	$1,434	$883	$1,480
14018898	EPO	$536	$911	$1,072	$1,528	$941	$1,577
14018912	MC	$537	$912	$1,073	$1,529	$941	$1,578
14018913	MC	$510	$867	$1,020	$1,454	$895	$1,500
14018905	EPO	$489	$831	$978	$1,393	$858	$1,438
14018908	Indemnity	$665	$1,130	$1,330	$1,895	$1,166	$1,956
14018897	EPO	$585	$995	$1,170	$1,668	$1,027	$1,721

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA06

New Plan Number	Plan	Single Premium Rate 4Q 2014	Parent & Child(ren) Premium Rate 4Q 2014	Couple Premium Rate 4Q 2014	Family Premium Rate 4Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 4Q 2014	With dependent up to age 30 rider: Family Premium Rate 4Q 2014
14018887	EPO	$407	$692	$814	$1,161	$714	$1,198
14018888	EPO	$399	$678	$797	$1,136	$700	$1,173
14018889	EPO	$378	$643	$757	$1,078	$664	$1,113
14018892	EPO	$412	$700	$824	$1,174	$723	$1,211
14018894	EPO	$402	$683	$803	$1,145	$705	$1,181
14018893	EPO	$398	$677	$797	$1,135	$699	$1,172
14018886	EPO	$481	$818	$963	$1,372	$845	$1,416
14018884	EPO	$524	$890	$1,047	$1,492	$919	$1,540
14018885	EPO	$558	$948	$1,116	$1,590	$979	$1,641
14018890	MC	$558	$949	$1,117	$1,591	$980	$1,642
14018895	MC	$531	$902	$1,062	$1,513	$931	$1,561
14018891	EPO	$509	$865	$1,017	$1,450	$893	$1,496
14018896	Indemnity	$692	$1,176	$1,384	$1,972	$1,214	$2,035
14018883	EPO	$609	$1,035	$1,218	$1,736	$1,068	$1,791
14018901	EPO	$404	$687	$809	$1,153	$709	$1,189
14018902	EPO	$396	$673	$792	$1,129	$695	$1,165
14018903	EPO	$376	$639	$752	$1,071	$659	$1,105
14018904	EPO	$409	$695	$818	$1,166	$718	$1,203
14018906	EPO	$399	$678	$798	$1,137	$700	$1,173
14018907	EPO	$396	$672	$791	$1,127	$694	$1,163
14018900	EPO	$474	$806	$949	$1,352	$832	$1,395
14018899	EPO	$516	$877	$1,032	$1,470	$905	$1,517
14018898	EPO	$550	$934	$1,099	$1,567	$964	$1,617
14018912	MC	$550	$935	$1,100	$1,568	$965	$1,618
14018913	MC	$523	$889	$1,046	$1,491	$918	$1,538
14018905	EPO	$501	$852	$1,002	$1,428	$879	$1,474
14018908	Indemnity	$682	$1,159	$1,363	$1,943	$1,196	$2,005
14018897	EPO	$600	$1,020	$1,200	$1,710	$1,053	$1,765

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA07

New Plan Number	Plan	Single Premium Rate 1Q 2014	Parent & Child(ren) Premium Rate 1Q 2014	Couple Premium Rate 1Q 2014	Family Premium Rate 1Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 1Q 2014	With dependent up to age 30 rider: Family Premium Rate 1Q 2014
14018887	EPO	$394	$670	$789	$1,124	$692	$1,160
14018888	EPO	$386	$656	$772	$1,100	$677	$1,135
14018889	EPO	$366	$623	$733	$1,044	$643	$1,078
14018892	EPO	$399	$678	$797	$1,136	$700	$1,173
14018894	EPO	$389	$661	$778	$1,108	$682	$1,144
14018893	EPO	$386	$656	$771	$1,099	$677	$1,134
14018886	EPO	$466	$792	$932	$1,328	$818	$1,371
14018884	EPO	$507	$862	$1,014	$1,445	$890	$1,491
14018885	EPO	$540	$918	$1,080	$1,540	$948	$1,589
14018890	MC	$541	$919	$1,081	$1,541	$948	$1,590
14018895	MC	$514	$874	$1,028	$1,465	$902	$1,512
14018891	EPO	$493	$837	$985	$1,404	$864	$1,449
14018896	Indemnity	$670	$1,139	$1,340	$1,909	$1,175	$1,970
14018883	EPO	$590	$1,002	$1,179	$1,681	$1,034	$1,734
14018901	EPO	$392	$666	$783	$1,116	$687	$1,152
14018902	EPO	$383	$652	$767	$1,093	$673	$1,128
14018903	EPO	$364	$619	$728	$1,037	$638	$1,070
14018904	EPO	$396	$673	$792	$1,129	$695	$1,165
14018906	EPO	$386	$657	$772	$1,101	$678	$1,136
14018907	EPO	$383	$651	$766	$1,091	$672	$1,126
14018900	EPO	$459	$781	$918	$1,309	$806	$1,351
14018899	EPO	$500	$849	$999	$1,424	$876	$1,469
14018898	EPO	$532	$905	$1,064	$1,517	$934	$1,565
14018912	MC	$533	$905	$1,065	$1,518	$934	$1,566
14018913	MC	$506	$861	$1,013	$1,443	$888	$1,489
14018905	EPO	$485	$825	$971	$1,383	$851	$1,427
14018908	Indemnity	$660	$1,122	$1,320	$1,881	$1,158	$1,941
14018897	EPO	$581	$988	$1,162	$1,656	$1,019	$1,709

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA07

New Plan Number	Plan	Single Premium Rate 2Q 2014	Parent & Child(ren) Premium Rate 2Q 2014	Couple Premium Rate 2Q 2014	Family Premium Rate 2Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 2Q 2014	With dependent up to age 30 rider: Family Premium Rate 2Q 2014
14018887	EPO	$404	$687	$808	$1,152	$709	$1,189
14018888	EPO	$396	$673	$792	$1,128	$694	$1,164
14018889	EPO	$376	$639	$751	$1,070	$659	$1,105
14018892	EPO	$409	$695	$818	$1,165	$717	$1,202
14018894	EPO	$399	$678	$797	$1,136	$699	$1,173
14018893	EPO	$395	$672	$791	$1,127	$694	$1,163
14018886	EPO	$478	$812	$956	$1,362	$838	$1,405
14018884	EPO	$520	$884	$1,040	$1,481	$912	$1,529
14018885	EPO	$554	$941	$1,108	$1,578	$972	$1,629
14018890	MC	$554	$942	$1,108	$1,579	$972	$1,630
14018895	MC	$527	$896	$1,054	$1,502	$924	$1,550
14018891	EPO	$505	$858	$1,010	$1,439	$886	$1,485
14018896	Indemnity	$687	$1,167	$1,373	$1,957	$1,205	$2,020
14018883	EPO	$604	$1,028	$1,209	$1,723	$1,060	$1,778
14018901	EPO	$401	$682	$803	$1,144	$704	$1,181
14018902	EPO	$393	$668	$786	$1,120	$690	$1,156
14018903	EPO	$373	$634	$746	$1,063	$654	$1,097
14018904	EPO	$406	$690	$812	$1,157	$712	$1,194
14018906	EPO	$396	$673	$792	$1,128	$695	$1,165
14018907	EPO	$393	$667	$785	$1,119	$689	$1,155
14018900	EPO	$471	$800	$942	$1,342	$826	$1,385
14018899	EPO	$512	$871	$1,024	$1,459	$898	$1,506
14018898	EPO	$546	$927	$1,091	$1,555	$957	$1,605
14018912	MC	$546	$928	$1,092	$1,556	$958	$1,606
14018913	MC	$519	$882	$1,038	$1,479	$911	$1,527
14018905	EPO	$497	$846	$995	$1,418	$873	$1,463
14018908	Indemnity	$677	$1,150	$1,353	$1,928	$1,187	$1,990
14018897	EPO	$596	$1,012	$1,191	$1,697	$1,045	$1,752

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA07

New Plan Number	Plan	Single Premium Rate 3Q 2014	Parent & Child(ren) Premium Rate 3Q 2014	Couple Premium Rate 3Q 2014	Family Premium Rate 3Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 3Q 2014	With dependent up to age 30 rider: Family Premium Rate 3Q 2014
14018887	EPO	$414	$704	$829	$1,181	$727	$1,219
14018888	EPO	$406	$690	$811	$1,156	$712	$1,193
14018889	EPO	$385	$655	$770	$1,097	$676	$1,133
14018892	EPO	$419	$712	$838	$1,194	$735	$1,233
14018894	EPO	$409	$695	$818	$1,165	$717	$1,202
14018893	EPO	$405	$689	$811	$1,155	$711	$1,192
14018886	EPO	$490	$833	$980	$1,396	$859	$1,441
14018884	EPO	$533	$906	$1,066	$1,519	$935	$1,567
14018885	EPO	$568	$965	$1,135	$1,618	$996	$1,670
14018890	MC	$568	$966	$1,136	$1,619	$997	$1,671
14018895	MC	$540	$918	$1,080	$1,539	$948	$1,589
14018891	EPO	$518	$880	$1,035	$1,475	$908	$1,523
14018896	Indemnity	$704	$1,197	$1,408	$2,007	$1,235	$2,071
14018883	EPO	$620	$1,054	$1,239	$1,766	$1,087	$1,823
14018901	EPO	$412	$700	$823	$1,173	$722	$1,210
14018902	EPO	$403	$685	$806	$1,148	$707	$1,185
14018903	EPO	$382	$650	$765	$1,090	$671	$1,125
14018904	EPO	$416	$707	$832	$1,186	$730	$1,224
14018906	EPO	$406	$690	$812	$1,157	$712	$1,194
14018907	EPO	$403	$684	$805	$1,147	$706	$1,184
14018900	EPO	$483	$820	$965	$1,376	$847	$1,420
14018899	EPO	$525	$892	$1,050	$1,496	$921	$1,544
14018898	EPO	$559	$951	$1,119	$1,594	$981	$1,645
14018912	MC	$560	$952	$1,119	$1,595	$982	$1,646
14018913	MC	$532	$905	$1,064	$1,517	$934	$1,565
14018905	EPO	$510	$867	$1,020	$1,454	$895	$1,500
14018908	Indemnity	$694	$1,179	$1,387	$1,977	$1,217	$2,040
14018897	EPO	$611	$1,038	$1,221	$1,740	$1,071	$1,796

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA07

New Plan Number	Plan	Single Premium Rate 4Q 2014	Parent & Child(ren) Premium Rate 4Q 2014	Couple Premium Rate 4Q 2014	Family Premium Rate 4Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 4Q 2014	With dependent up to age 30 rider: Family Premium Rate 4Q 2014
14018887	EPO	$425	$722	$850	$1,211	$745	$1,250
14018888	EPO	$416	$707	$832	$1,186	$730	$1,224
14018889	EPO	$395	$671	$790	$1,125	$693	$1,161
14018892	EPO	$430	$730	$859	$1,225	$754	$1,264
14018894	EPO	$419	$712	$838	$1,194	$735	$1,233
14018893	EPO	$416	$706	$831	$1,184	$729	$1,222
14018886	EPO	$502	$854	$1,005	$1,431	$881	$1,477
14018884	EPO	$546	$929	$1,093	$1,557	$958	$1,607
14018885	EPO	$582	$990	$1,164	$1,659	$1,021	$1,712
14018890	MC	$582	$990	$1,165	$1,660	$1,022	$1,713
14018895	MC	$554	$941	$1,108	$1,578	$972	$1,629
14018891	EPO	$531	$902	$1,062	$1,513	$931	$1,561
14018896	Indemnity	$722	$1,227	$1,444	$2,057	$1,266	$2,123
14018883	EPO	$635	$1,080	$1,271	$1,811	$1,115	$1,869
14018901	EPO	$422	$717	$844	$1,202	$740	$1,241
14018902	EPO	$413	$702	$826	$1,177	$725	$1,215
14018903	EPO	$392	$666	$784	$1,117	$688	$1,153
14018904	EPO	$427	$725	$853	$1,216	$749	$1,255
14018906	EPO	$416	$707	$832	$1,186	$730	$1,224
14018907	EPO	$413	$702	$825	$1,176	$724	$1,214
14018900	EPO	$495	$841	$990	$1,410	$868	$1,455
14018899	EPO	$538	$915	$1,077	$1,534	$944	$1,583
14018898	EPO	$573	$975	$1,147	$1,634	$1,006	$1,687
14018912	MC	$574	$976	$1,148	$1,636	$1,007	$1,688
14018913	MC	$546	$928	$1,091	$1,555	$957	$1,605
14018905	EPO	$523	$889	$1,046	$1,490	$917	$1,538
14018908	Indemnity	$711	$1,209	$1,422	$2,027	$1,248	$2,092
14018897	EPO	$626	$1,064	$1,252	$1,784	$1,098	$1,841

1Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA08

New Plan Number	Plan	Single Premium Rate 1Q 2014	Parent & Child(ren) Premium Rate 1Q 2014	Couple Premium Rate 1Q 2014	Family Premium Rate 1Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 1Q 2014	With dependent up to age 30 rider: Family Premium Rate 1Q 2014
14018887	EPO	$394	$670	$788	$1,123	$691	$1,159
14018888	EPO	$386	$656	$772	$1,100	$677	$1,135
14018889	EPO	$366	$622	$732	$1,043	$642	$1,077
14018892	EPO	$398	$677	$797	$1,136	$699	$1,172
14018894	EPO	$389	$661	$777	$1,108	$682	$1,143
14018893	EPO	$385	$655	$771	$1,098	$676	$1,134
14018886	EPO	$466	$792	$932	$1,327	$817	$1,370
14018884	EPO	$507	$861	$1,013	$1,444	$889	$1,490
14018885	EPO	$540	$918	$1,080	$1,538	$947	$1,588
14018890	MC	$540	$918	$1,080	$1,540	$948	$1,589
14018895	MC	$514	$873	$1,027	$1,464	$901	$1,511
14018891	EPO	$492	$837	$984	$1,403	$864	$1,448
14018896	Indemnity	$669	$1,138	$1,339	$1,908	$1,174	$1,969
14018883	EPO	$589	$1,002	$1,178	$1,679	$1,034	$1,733
14018901	EPO	$391	$665	$783	$1,115	$686	$1,151
14018902	EPO	$383	$651	$766	$1,092	$672	$1,127
14018903	EPO	$364	$618	$727	$1,036	$638	$1,069
14018904	EPO	$396	$673	$791	$1,128	$694	$1,164
14018906	EPO	$386	$656	$772	$1,100	$677	$1,135
14018907	EPO	$383	$651	$765	$1,091	$671	$1,126
14018900	EPO	$459	$780	$918	$1,308	$805	$1,350
14018899	EPO	$499	$849	$998	$1,423	$876	$1,468
14018898	EPO	$532	$904	$1,064	$1,516	$933	$1,564
14018912	MC	$532	$905	$1,064	$1,517	$934	$1,565
14018913	MC	$506	$860	$1,012	$1,442	$888	$1,488
14018905	EPO	$485	$824	$970	$1,382	$851	$1,426
14018908	Indemnity	$660	$1,121	$1,319	$1,880	$1,157	$1,940
14018897	EPO	$581	$987	$1,161	$1,655	$1,018	$1,707

2Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA08

New Plan Number	Plan	Single Premium Rate 2Q 2014	Parent & Child(ren) Premium Rate 2Q 2014	Couple Premium Rate 2Q 2014	Family Premium Rate 2Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 2Q 2014	With dependent up to age 30 rider: Family Premium Rate 2Q 2014
14018887	EPO	$404	$687	$808	$1,151	$709	$1,188
14018888	EPO	$395	$672	$791	$1,127	$694	$1,163
14018889	EPO	$375	$638	$751	$1,070	$658	$1,104
14018892	EPO	$408	$694	$817	$1,164	$717	$1,201
14018894	EPO	$398	$677	$797	$1,136	$699	$1,172
14018893	EPO	$395	$672	$790	$1,126	$693	$1,162
14018886	EPO	$477	$812	$955	$1,361	$838	$1,404
14018884	EPO	$519	$883	$1,039	$1,480	$911	$1,528
14018885	EPO	$553	$941	$1,107	$1,577	$971	$1,628
14018890	MC	$554	$941	$1,108	$1,578	$972	$1,629
14018895	MC	$527	$895	$1,053	$1,501	$924	$1,549
14018891	EPO	$505	$858	$1,009	$1,438	$885	$1,484
14018896	Indemnity	$686	$1,167	$1,373	$1,956	$1,204	$2,018
14018883	EPO	$604	$1,027	$1,208	$1,722	$1,060	$1,777
14018901	EPO	$401	$682	$802	$1,143	$704	$1,180
14018902	EPO	$393	$668	$785	$1,119	$689	$1,155
14018903	EPO	$373	$634	$745	$1,062	$654	$1,096
14018904	EPO	$406	$690	$811	$1,156	$712	$1,193
14018906	EPO	$396	$673	$791	$1,128	$694	$1,164
14018907	EPO	$392	$667	$785	$1,118	$688	$1,154
14018900	EPO	$470	$800	$941	$1,341	$825	$1,384
14018899	EPO	$512	$870	$1,023	$1,458	$898	$1,505
14018898	EPO	$545	$927	$1,090	$1,554	$956	$1,604
14018912	MC	$546	$927	$1,091	$1,555	$957	$1,605
14018913	MC	$519	$882	$1,037	$1,478	$910	$1,526
14018905	EPO	$497	$845	$994	$1,417	$872	$1,462
14018908	Indemnity	$676	$1,149	$1,352	$1,927	$1,186	$1,989
14018897	EPO	$595	$1,012	$1,190	$1,696	$1,044	$1,750

3Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA08

New Plan Number	Plan	Single Premium Rate 3Q 2014	Parent & Child(ren) Premium Rate 3Q 2014	Couple Premium Rate 3Q 2014	Family Premium Rate 3Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 3Q 2014	With dependent up to age 30 rider: Family Premium Rate 3Q 2014
14018887	EPO	$414	$704	$828	$1,180	$726	$1,218
14018888	EPO	$405	$689	$811	$1,156	$711	$1,193
14018889	EPO	$385	$654	$770	$1,097	$675	$1,132
14018892	EPO	$419	$712	$838	$1,194	$735	$1,232
14018894	EPO	$408	$694	$817	$1,164	$717	$1,201
14018893	EPO	$405	$689	$810	$1,154	$711	$1,191
14018886	EPO	$490	$832	$979	$1,395	$859	$1,440
14018884	EPO	$532	$905	$1,065	$1,518	$934	$1,566
14018885	EPO	$567	$964	$1,135	$1,617	$995	$1,669
14018890	MC	$568	$965	$1,135	$1,618	$996	$1,670
14018895	MC	$540	$918	$1,080	$1,538	$947	$1,588
14018891	EPO	$517	$879	$1,035	$1,474	$908	$1,522
14018896	Indemnity	$704	$1,196	$1,407	$2,005	$1,234	$2,069
14018883	EPO	$619	$1,053	$1,239	$1,765	$1,086	$1,821
14018901	EPO	$411	$699	$822	$1,172	$721	$1,209
14018902	EPO	$403	$684	$805	$1,148	$706	$1,184
14018903	EPO	$382	$650	$764	$1,089	$670	$1,124
14018904	EPO	$416	$707	$832	$1,185	$730	$1,223
14018906	EPO	$406	$690	$811	$1,156	$712	$1,193
14018907	EPO	$402	$684	$804	$1,146	$706	$1,183
14018900	EPO	$482	$820	$965	$1,375	$846	$1,419
14018899	EPO	$525	$892	$1,049	$1,495	$920	$1,543
14018898	EPO	$559	$950	$1,118	$1,593	$981	$1,644
14018912	MC	$559	$951	$1,119	$1,594	$981	$1,645
14018913	MC	$532	$904	$1,064	$1,516	$933	$1,564
14018905	EPO	$510	$866	$1,019	$1,453	$894	$1,499
14018908	Indemnity	$693	$1,178	$1,386	$1,976	$1,216	$2,039
14018897	EPO	$610	$1,037	$1,220	$1,739	$1,070	$1,795

4Q 2014 Rate Summary

Rate Tables - Medical Plans

NYRA08

New Plan Number	Plan	Single Premium Rate 4Q 2014	Parent & Child(ren) Premium Rate 4Q 2014	Couple Premium Rate 4Q 2014	Family Premium Rate 4Q 2014	With dependent up to age 30 rider: Parent & Child(ren) Premium Rate 4Q 2014	With dependent up to age 30 rider: Family Premium Rate 4Q 2014
14018887	EPO	$425	$722	$849	$1,210	$745	$1,249
14018888	EPO	$416	$707	$831	$1,185	$729	$1,223
14018889	EPO	$395	$671	$789	$1,124	$692	$1,160
14018892	EPO	$429	$730	$859	$1,224	$753	$1,263
14018894	EPO	$419	$712	$838	$1,194	$735	$1,232
14018893	EPO	$415	$706	$831	$1,184	$729	$1,221
14018886	EPO	$502	$853	$1,004	$1,430	$881	$1,476
14018884	EPO	$546	$928	$1,092	$1,556	$958	$1,606
14018885	EPO	$582	$989	$1,163	$1,658	$1,020	$1,711
14018890	MC	$582	$990	$1,164	$1,659	$1,021	$1,712
14018895	MC	$553	$941	$1,107	$1,577	$971	$1,628
14018891	EPO	$530	$902	$1,061	$1,512	$930	$1,560
14018896	Indemnity	$721	$1,226	$1,443	$2,056	$1,266	$2,122
14018883	EPO	$635	$1,079	$1,270	$1,810	$1,114	$1,867
14018901	EPO	$422	$717	$843	$1,202	$740	$1,240
14018902	EPO	$413	$702	$826	$1,177	$724	$1,214
14018903	EPO	$392	$666	$784	$1,117	$687	$1,152
14018904	EPO	$426	$725	$853	$1,215	$748	$1,254
14018906	EPO	$416	$707	$832	$1,185	$730	$1,223
14018907	EPO	$412	$701	$825	$1,175	$723	$1,213
14018900	EPO	$494	$841	$989	$1,409	$868	$1,454
14018899	EPO	$538	$914	$1,076	$1,533	$944	$1,582
14018898	EPO	$573	$974	$1,146	$1,633	$1,005	$1,686
14018912	MC	$573	$975	$1,147	$1,634	$1,006	$1,687
14018913	MC	$545	$927	$1,090	$1,554	$957	$1,604
14018905	EPO	$523	$888	$1,045	$1,489	$917	$1,537
14018908	Indemnity	$711	$1,208	$1,421	$2,025	$1,247	$2,090
14018897	EPO	$626	$1,063	$1,251	$1,783	$1,097	$1,840

List of Small Group Off-Exchange Forms

Small Group EPO Plans

OffHIXSGEPOGR-96817
OffHIXSGEPOGR-96817-Contra Rider
OffHIXSGEPOGR-96817-Deps Age 29
OffHIXSGEPOGR-96823
OffHIXSGEPOGR-96823-Contra Rider
OffHIXSGEPOGR-96823-Deps Age 29
OffHIXSG(EPObronze2500100%HSAPY)GR-96823-SB
OffHIXSG(EPOBronze350050%)GR-96817-SB
OffHIXSG(EPOBronze350060%HSAPY)GR-96823-SB
OffHIXSG(EPOBronze400080%)GR-96817-SB
OffHIXSG(EPOBronze500060%)GR-96817-SB
OffHIXSG(EPOBronze5000100%HSAPY)GR-96823-SB
OffHIXSG(EPOGold100090%)GR-96817-SB
OffHIXSG(EPOSilver200060%)GR-96817-SB
OffHIXSG(EPOSilver200080%HSAPY)GR-96823-SB
OffHIXSG(EPOSilver200090%)GR-96817-SB
OffHIXSG(EPOSilver300070%)GR-96817-SB

Small Group OAMC Plans

OffHIXSGOAMCGR-96819
OffHIXSGOAMCGR-96819 –Contra Rider
OffHIXSGOAMCGR-96819-Deps Age 29
OffHIXSGOAMCGR-96824
OffHIXSGOAMCGR-96824 –Contra Rider
OffHIXSGOAMCGR-96824-Deps Age 29
OffHIXSG(OAMCSilver80%/60%HSAPY)GR-96824-SB
OffHIXSG(OAMCSilver80%/60%)GR-96819-SB

Small Group Indemnity Plans

OffHIXSGINDEMGR-96820
OffHIXSGINDEMGR-96820-Contra Rider
OffHIXSGINDEMGR-96820-Deps Age 29
OffHIXSG(IndemSilver250080%)GR-96820-SB

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

New York Employer Groups with Fewer than 50 Employees	
Incurred Claims	82.8%
General Expenses	3.8%
ACA Taxes and Fees	3.6%
Premium Taxes	1.6%
Commissions	6.1%
FIT + Profit	2.0%
Total	100.0%
After FIT Profit	1.3%

FIT = Federal Income Tax

Loss Ratio for Small Group Coverages

The ALIC small group non-HMO product's projected loss ratio for customers with rate increases effective for the 4 quarters provided in this filing (1Q2014-4Q2014) would be 82.8%. This reflects actual membership, premium, and claim experience since our submitted plan as well as adjustments for lapses and buy-downs per our plan. Note that we expect the loss ratio for calendar year 2014 is in excess of the 82% statutory minimum. The claim trend assumption underlying this analysis is 11.8%.

The administrative expense assumptions underlying this analysis are approximately 15.2%, comprised of 6.1% for commissions, 1.6% for premium taxes with the remaining 7.5% for other selling and general administrative expenses including 3.6% to cover ACA related taxes and fees (RC and HIF), details of these taxes and fees are discussed in actuarial memorandum.

Exhibit B
Outline of General Underwriting and Marketing Methods

Aetna 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 employer groups, with no preexisting condition limitations or benefit waiting periods. Aetna Life Insurance Company makes available to these groups only those products and rates filed and approved, and compliant with all insurance laws, regulations and practices in the state of New York.

Exhibit C
Commissions Schedule and Incentive Fees

The commission schedule for 2014 has not been finalized. We currently estimated commissions to be at 6.1% of premium. We will make the appropriate adjustments once the commission schedule is finalized.

Supporting Document Schedules

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

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	NY Cert_ALIC_off exchange SG.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - NY SG Actuarial Memo ALIC.pdf
Item Status:	
Status Date:	

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

Bypassed - Item:	Small Group Rate Intructions/Checklist
Bypass Reason:	No need to submit checklist
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only
Product Name: NY SG ALIC 1Q14-4Q14
Project Name/Number: /

Comments:	
Attachment(s):	NY SG Rate Manual - B_Ex A_NY SG PPO AV and Product Summary 2013 05 07.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 1-General Information
Comments:	
Attachment(s):	Required Exhibit 1 ALIC 1Q14-4Q14.pdf Required Exhibit 1 ALIC 1Q14-4Q14.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 7-Historical Data
Comments:	
Attachment(s):	Required Exhibit 7 ALIC 1Q14-4Q14.pdf Required Exhibit 7 ALIC 1Q14-4Q14.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 8-Adjustment Factors to Index Rate
Comments:	
Attachment(s):	Required Exhibit 8 ALIC 1Q14-4Q14.pdf Required Exhibit 8 ALIC 1Q14-4Q14.xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 9-Summary of Administrative Expenses
Comments:	
Attachment(s):	Required Exhibit 9 ALIC 1Q14-4Q14.pdf Required Exhibit 9 ALIC 1Q14-4Q14.xls
Item Status:	
Status Date:	

State: New York **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only
Product Name: NY SG ALIC 1Q14-4Q14
Project Name/Number: /

Bypassed - Item:	Redacted Documents for Web Posting-NG Off Exchange
Bypass Reason:	No redactions
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	Part II_SG PPO - NY.pdf Unified_Rate_Review_Template_NY_SG_PPO - Value.pdf Unified_Rate_Review_Template_NY_SG_PPO - Value.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter
Comments:	
Attachment(s):	ALIC NY SG Off-Exchange Cov Letter.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Form List
Comments:	
Attachment(s):	List of Small Group Off.pdf
Item Status:	
Status Date:	

Review Standards for

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

Instructions for SERFF Checklist:

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

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

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

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

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

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

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

LINE OF BUSINESS: **Group Major Medical or Similar-Type Comprehensive Health Insurance**

CODE:			LINE(S) OF INSURANCE	CODES
	H15G	Health	– Hospital/Surgical/Medical Expense	H15G.001
		H15		G.002
		H15		G.003
	H16G	Health	– Major Medical H16	G.001A
		H16		G.001B
				H16G.001C
		H16		G.002A
				H16G.002C
		H16		G.003A
				H16G.003D

H16 G.003G

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

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

		(If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on March 16, 2007, submission number 2005100113.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF.	
Flesch Score	§3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	See Readability Certification
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF Filing Description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form is a policy or contract, the letter must indicate that the policy or contract is submitted pursuant to 11 NYCRR 52.7. §52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f) • If the form is other than a policyor contract form, the letter must identify the form number and	

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

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

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

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

		insured can obtain such referral.	
Specialty Care Provider as PCP Model Language Used? Yes ☒ No ☐	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	
Standing Referrals Model Language Used? Yes ☒ No ☐	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	
Specialty Care Center Model Language Used? Yes ☒ No ☐	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	
Transitional Care When A Provider Leaves the Network Model Language Used? Yes ☒ No ☐	§4804(e) §3217-d(c) §4306-C(c) PHL §4403(6)(e) Model Language	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ☒ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

		• The stand alone dental plan complies with all ACA provisions and CMS regulations pertaining to stand alone dental plans; *• Insurers should specifically describe the legal and business arrangement between the medical issuer and the dental issuer when submitting the forms and rates to DFS, and each insurer must separately submit its own forms and rates for approval.* *If the insurer is reasonably assured that an individual has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange the insurer does not need to provide the dental benefit when coverage is issued. Insurers may include a question in their application/enrollment form in order to verify whether an insured has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange*	
Explanation:			
ADDITIONAL BENEFITS			
Family Vision Model Language Used? Yes ☒ No ☐	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	
Orthotics Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	http://public.leginfo.state.ny.us/menugetf.cgi?COMMONQUERY=LAWS11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	
Explanation:			

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

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

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

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

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

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

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

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

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

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

		network coverage unless supported by scholarly literature or actual claims experience of the insurer.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for SHOP On-Exchange Plans and Off-Exchange Plans" has been posted on the Department website and on SERFF.** *Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.* *For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.*	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3221 11NYCRR52.40(e) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Small Group: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(l)(5). c. Actuarial justification for the use of claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio 82.8 %.	Supporting Documentation: NY SG ALIC Act Memo.pdf
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	ALIC Rate Manual-Section F
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	Supporting Documentation: NY SG ALIC Act Memo.pdf
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: 82.8 %.	ALIC Rate Manual-Section F

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

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

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 _____.

[X] 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

[x] 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

[x] 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.

[x] 2. It is printed in no less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables).

[x] 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

[x] 4. The section titles are captioned in bold face or otherwise stand out significantly from the text.

[x] 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

[x] 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.

[x] 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.)

[redacted]
Officer's Name

Assistant Vice President
Officer's Title

Date May 15, 2013

SWH/al

Aetna Life Insurance Company.

Form #	Sentences	Words	Syllables	Flesch Score
OffHIXSGEPOGR-96817				33.7*
OffHIXSGEPOGR-96817-Contra Rider				31.7*
OffHIXSGEPOGR-96817-DepsAge 29				51.8
OffHIXSGEPOGR-96823				33.7*
OffHIXSGEPOGR-96823-Contra Rider				31.7*
OffHIXSGEPOGR-96823-DepsAge 29				51.8
OffHIXSGOAMCGR-96819				33.7*
OffHIXSGOAMCGR-96819-Contra Rider				31.7*
OffHIXSGOAMCGR-96819-DepsAge 29				51.8
OffHIXSGEPOGR-96824				33.7*
OffHIXSGEPOGR-96824-Contra Rider				31.7*
OffHIXSGEPOGR-96824-DepsAge 29				51.8
OffHIXSGINDEMGR-96820				33.7*
OffHIXSGINDEMGR-96820-Contra Rider				31.7*
OffHIXSGINDEMGR-96820-DepsAge 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
Actuarial Memorandum
SERFF ID: AETN-128993202

Comprehensive Small Group Medical Expense Benefit Plans

Purpose, Scope and Proposed Effective Date

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

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

Benefit Design

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

The Premium Rate Manual included in this rate filing contains worksheets and instructions for calculating the premium rates for the benefit plans available from Aetna Life Insurance Company.

Applicability

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

Renewability Clause

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

Determination of Claim Portion of Market Index Rate

In setting the projected claim level in the market in 2014, we based our projections upon the experience of our current small group block of Aetna Life Insurance Company business in NY. We made adjustments as appropriate in order to project the experience claims forward and account for the expected market dynamics in 2014.

Summary Discussion: First the existing experience claims are normalized. An adjustment is made to bring the claims to the current mix of business by area, benefit plan, etc. We further adjust for the difference between the current average benefit level and the anchor Silver plan. This provides a normalized claim base to project forward. Aetna then applied medical cost trend to project the claims from the experience period to the 2014 rating period. Our trend assumption is 11.8%, incorporating our expectations of utilization and unit cost. The resulting projected claim amount represents the expected claim PMPM for our anchor Silver plan.

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

1. Paid Claims PMPM (#2): Experience for the period 10/01/11 through 09/30/12, paid through 12/31/12. This is the average PMPM incurred claims for the experience period. We exclude from this PMPM amount any adjustments for the impact of the current Regulation 146 risk adjustment pool and Stop-Loss Reimbursement pool. Reserves - Claims Incurred But Not Paid were estimated using standard lag methods. We used three month of runoff to reduce the reliance on reserve estimates. The reserves represent 1.2% of the experience period claims.
2. Benefit Normalization (#3): Normalizes the baseline experience to the ending mix of benefit levels using historical Aetna benefit index data.
    a. Average AV pricing value for all inforce plans in effect during the experience period, based on member-months.
    b. Difference between the ending mix of benefit levels in the experience period and the benefit level of the selected anchor Silver plan.
    c. EHB adjustment for the value of additional Essential Health Benefits (EHB) as a percentage of the selected Silver plan
3. Tier ratio adjustment (#5): Adjust the current Tier ratio relationship to the NY Department of Financial Services (NY DFS or DFS) prescribed tier ratios.
4. Market Level Risk Adjustment (#6): Estimate of the impact of the federal risk adjustment program. The impact of risk adjustment in the 2014 NY small group marketplace was based on the simulation study conducted by Deloitte on behalf of DFS. Our own analysis of the block indicates stable morbidity and health status, consistent with the data provided to Deloitte, and we do not expect material changes in 2014. Based on these projections of the market in 2014, this adjustment is -11.2%.
5. Allowed Trend (#8): Annual trend on allowed costs incorporating our expectations of utilization and unit cost. We utilized Aetna Small Group community rated NY EPO and MC experience for the period 10/01/11 through 09/30/12 with run-out through 12/31/12 in order to project claims for this filing. No adjustments were made for large claims. The historical claims are normalized for demographics, tier, benefit changes, case size, and area to the most recent month of the experience period, and a three month lagged annual experience period weighted average PMPM is calculated and projected forward with trend and seasonality. The medical trend assumptions are based on our small group EPO and MC experience. For this rate filing, we have used 11.8% as the projected change in medical cost.
6. Claim Trend Factor (#9): Midpoint of experience period of 10/1/11 to 9/30/12 is 4/1/12. Midpoint of 1Q2014 (1/1/14 to 3/31/14) is 2/15/14. This yields a projection period of 22.5 months.

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

Determination of Retention Portion of Market Index Rate

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

1. Taxes and Fees of 5.3% comprised of:
    a. Premium Taxes of 1.6 %
    b. Patient Centered Outcomes Research Fund of $2.00 per member per year, converted to 0.04%
    c. Reinsurance Contribution of $5.12 PMPM, converted to 1.1% based on effective date to account for differences in the contribution level year over year, please see the separate section below
    d. Health Insurer Fee of 2.6% based on effective date to account for differences in the fee level year over year, please see the separate section below
    e. As requested, we did not include any Exchange Fee in the 2014 rate filing
2. Commissions of 6.3% comprised of:
    a. Variable Commissions of 6.3%
3. General Administrative Expenses of 4.0% comprised of Fixed expenses of $19.30, converted to a percentage of premium
4. Risk Charge of 2.0%

Impact of PPACA Taxes and Fees

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

1. Reinsurance Contribution (RC): This is a temporary fee, designed to fund the temporary reinsurance program that will cover the individual markets for the years 2014 through 2016. The fee is assessed on fully insured and self-insured group health plans. There will be a standard national assessment for the RC, as well as the option for states to assess an additional state-level assessment. The total amount to be collected under the national assessment in 2014 is $12 billion, declining to $8 billion in 2015 and $5 billion in 2016. Aetna has calculated the impact for the 2014 RC fee based on the final regulation for policies issued in NY to be worth approximately 0.9% of premium.

2. Health Insurer Fee (HIF): This permanent industry fee will be assessed based on each insurer's share of the fully insured market, in order to collect a total of $8.0 billion for 2014. The total assessment will increase each year, to $14.3 billion in 2018 and increasing at the rate of premium growth thereafter. Aetna has calculated the impact for the 2014 HIF fee based on current regulations to be approximately 2.7% of premium.

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

Renewal / Effective Date	No. of Months of Premium in 2014	No. of Months of Premium in 2015	RC Factor	HIF Factor	Total Premium Impact
1Q14	12	0	1.011	1.026	3.7%
2Q14	9	3	1.010	1.027	3.7%
3Q14	6	6	1.009	1.027	3.6%
4Q14	3	9	1.007	1.028	3.5%

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

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

The final Market Index Rate was calculated as Projected Claims / (1 – Taxes and Fees – Commissions – General Administrative Expenses – Risk Charge) to be $484.86. This rate represents the proposed base premium rate PMPM for our anchor Silver plan provided in Table 1b attached below, and will be used as the basis for developing the plan premium rate PMPM for all other metallic-level plan designs discussed in this filing.

Rating Methodology

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

Rate Formula

For each subscriber, calculate the Premium Rate as follows:

Market Index Rate * Trend Factor * Area Factor * Plan Factor

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

Market Index Rate

The Market Index Rate for this filing is $484.86, developed as described above.

Trend Factors – effective date factor

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

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

The factors are:

Effective Date	Effective Date factor
1Q14	1.0000
2Q14	1.0251
3Q14	1.0510
4Q14	1.0775

The medical trend assumptions are based on our small group EPO and MC experience. Actual historical net claims were reviewed for the period 10/01/11 through 09/30/12 with run-out through 12/31/12. No adjustments were made for large claims. The historical claims are normalized for demographics, tier, benefit changes, case size, and area to the most recent month of the experience period, and a three month lagged annual experience period weighted average PMPM is calculated and projected forward with trend and seasonality. For this rate filing, we have used 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.

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

Type of Service	Unit Cost	Utilization	Total
Inpatient Hospital	4.2%	7.3%	11.8%
Outpatient Hospital	4.2%	7.3%	11.8%
Professional	4.2%	7.3%	11.8%
Other Medical	4.2%	7.3%	11.8%
Capitation	0.0%	0.0%	0.00%
Prescription Drug	4.2%	7.3%	11.8%
Total			11.8%

Area Factors

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

For 2014, these factors are consistent with our currently filed area factors, remapped by county for changes in the defined 2014 rating areas compared to our current rating area definitions. To validate the currently filed factors, experience was reviewed at the county level, normalized for demographics and health status, and adjusted for credibility. This analysis called for no changes to our Area Factors in our judgment, short of the afore-mentioned remapping to align with the 2014 defined areas.

Plan Factors

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

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

Final plan factors reflect the value of the EHB and state mandated benefits, incorporating the impact of out-of-network benefits and additional benefits. The methodology also considers the value of any differences in network by plan, including but not limited to network discounts and steerage.

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

The factors and also the HHS AV vales for each plan are shown in Table 3 attached.

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 ASOPs No. 5, 12, 23, 25 and 41. I also certify that the expected loss ratio incorporated into the rate tables meets the minimum requirements of the State of New York. I assert that the benefits are reasonable in relation to the premiums, and that the calculations are based on my best estimate of the future experience. I further attest that to the best of my knowledge, the rates are not excessive, inadequate, or unfairly discriminatory.

[redacted]

_____ _____5/15/2013_____

[redacted] Date

Aetna Life Insurance Company

Aetna Life Insurance Company
New York Small Group
SERFF Tracking Number: AETN-128993202

Table 1a
Market Index Rate Development

			Small Group PPO
1)	**Member Months (Oct 11-Sep 12)**		348,588
2)	**Paid Claims PMPM (Oct 11-Sep 12)**		$355.43
3)	Normalize:		
	a) Weighted Average Benefit Factor	/	0.7840
	b) Benefit Index for Silver Plan	x	0.7144
	c) EHB Adjustment	x	1.0244
4)	Normalized PMPM Claims Subtotal	=	**$331.78**
5)	Tier Ratio Adjustment	x	1.0922
6)	Market Level Risk Adjustment	x	0.8878
7)	**Comparative HCR Claims per Segment**	=	**$321.71**
8)	Allowed Claim Trend - Rate		11.80%
	No. of Months		22.5
9)	Claim Trend Factor	x	**1.2326**
10)	**Silver Index Base Claim Rate**	=	**$396.54**
11)	Pediatric Dental	+	$2.93
12)	**Silver Index Final Claim Rate**	=	**$399.47**
13)	1 - Retention	/	82.39%
14)	**Silver Index Premium Rate**	=	**$484.86**

Table 1b *NY SILVER BASE OAMC*

Summary of Benefits Covered

NY Silver Base OAMC Plan

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$3,000	$5,000
Family	$6,000	$10,000
Coinsurance	30%	50%
(Member Responsibility)		
	$0 once out-of-pocket max is satisfied	
Out-of-Pocket Maximum		
Individual	$6,400	$10,000
Familiy	$12,800	$20,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness		
(excludes Preventative and X-ray(s)	$30 per visit	50% after deductible
Specialist Visit	$60 per visit	50% after deductible
All Inpatient Hospital Services		
(includes Mental/Behavioral Health and Substance Abuse)	30% after deductible	50% after deductible
Emergency Room Services	$350 per visit	50% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$60 per visit	50% after deductible
Imaging (CT/PET Scans, MRIs)	30% after deductible	50% after deductible
Rehabilitative Speech Therapy	30% after deductible	50% after deductible
Rehabilitative Occupational and Rehabillitative Physical Therapy	30% after deductible	50% after deductible
Preventative Care/Screening/Immunization	0%	50% after deductible
Laboratory Outpatient and Professional Services	30% after deductible	50% after deductible
X-rays and Diagnostic Imaging	30% after deductible	50% after deductible
Skilled Nursing Facility	30% after deductible	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% after deductible	50% after deductible
Outpatient Surgery Physician/Surgical Services	30% after deductible	50% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	$500	$500
Family	$1,000	$1,000
Generics	$15 copay	$15 copay
Preferred Brand Drugs	$40 copay	$40 copay
Non-Preferred Brand Drugs	$70 copay	$70 copay
Specialty Drugs(i.e. high-cost)	$70 copay	$70 copay

Aetna Life Insurance Company
New York Small Group

NY SILVER BASE 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: Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$500.00	$3,000.00			
Coinsurance (%, Insurer's Cost Share)	70.28%	100.00%				
OOP Maximum ($)	$6,400.00		$6,400.00			
OOP Maximum if Separate ($)	$6,400.00	$0.00				

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$350.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$60.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	70%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	70%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	70%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	70%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	70%		☑	☑		
Skilled Nursing Facility	☑	☑	70%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	70%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	71%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$15.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

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

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

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

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

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 69.8%
Metal Tier: Silver

This product, NY Silver Base OAMC plan, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 69.8%.

Aetna Life Insurance Company
New York Small Group

Table 2
Rating Area Factors

Rating Region	Counties	Area Factor
Region 1	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	0.9879
Region 2	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	1.1600
Region 3	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster	0.8482
Region 4	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester	0.9689
Region 5	Livingston, Monroe, Ontario, Seneca, Wayne, Yates	0.8400
Region 6	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins	0.9472
Region 7	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	0.9882
Region 8	Nassau, Suffolk	0.9875

Aetna Life Insurance Company
New York Small Group

Table 3
AV and Plan factors

PPID	Plan	Exchange ON/OFF	Metallic Tier	Actuarial Value	Plan Factors
14018883	NY Gold OAEPO 1000 90%	OFF	Gold	79.3%	1.231
14018884	NY Silver OAEPO 2000 60%	OFF	Silver	71.8%	1.058
14018885	NY Silver OAEPO 2000 90%	OFF	Silver	72.0%	1.127
14018886	NY Silver OAEPO 3000 70%	OFF	Silver	68.3%	0.973
14018887	NY Bronze OAEPO 3500 50%	OFF	Bronze	61.9%	0.823
14018888	NY Bronze OAEPO 4000 80%	OFF	Bronze	61.3%	0.806
14018889	NY Bronze OAEPO 5000 60%	OFF	Bronze	61.4%	0.765
14018890	NY Silver OAMC 2000 80/60	OFF	Silver	68.8%	1.128
14018891	NY Silver OAEPO 2000 80% HSA PY	OFF	Silver	72.0%	1.028
14018892	NY Bronze OAEPO 2500 100% HSA PY	OFF	Bronze	61.2%	0.832
14018893	NY Bronze OAEPO 5000 100% HSA PY	OFF	Bronze	61.7%	0.805
14018894	NY Bronze OAEPO 3500 60% HSA PY	OFF	Bronze	62.0%	0.812
14018895	NY Silver OAMC 2000 80/60 HSA PY	OFF	Silver	72.0%	1.073
14018896	NY Silver Indemnity 2500 80%	OFF	Silver	68.6%	1.398
14018897	NY Gold OAEPO 1000 90% RE	OFF	Gold	79.3%	1.212
14018899	NY Silver OAEPO 2000 60% RE	OFF	Silver	71.8%	1.043
14018898	NY Silver OAEPO 2000 90% RE	OFF	Silver	72.0%	1.111
14018900	NY Silver OAEPO 3000 70% RE	OFF	Silver	68.3%	0.958
14018901	NY Bronze OAEPO 3500 50% RE	OFF	Bronze	61.9%	0.817
14018902	NY Bronze OAEPO 4000 80% RE	OFF	Bronze	61.3%	0.800
14018903	NY Bronze OAEPO 5000 60% RE	OFF	Bronze	61.4%	0.759
14018912	NY Silver OAMC 2000 80/60 RE	OFF	Silver	68.8%	1.112
14018905	NY Silver OAEPO 2000 80% HSA PY RE	OFF	Silver	72.0%	1.013
14018904	NY Bronze OAEPO 2500 100% HSA PY RE	OFF	Bronze	61.2%	0.826
14018907	NY Bronze OAEPO 5000 100% HSA PY RE	OFF	Bronze	61.7%	0.799
14018906	NY Bronze OAEPO 3500 60% HSA PY RE	OFF	Bronze	62.0%	0.806
14018913	NY Silver OAMC 2000 80/60 HSA PY RE	OFF	Silver	72.0%	1.057
14018908	NY Silver Indemnity 2500 80% RE	OFF	Silver	68.6%	1.377

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: Small Group
- Effective Date: 1/1/2014

Company Contact Information:

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

Proposed Rate Increase(s)

No rate increase is proposed in this filing.

Experience Period Premium and Claims

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

Premiums (net of MLR Rebate) in Experience Period: The premiums shown are date-of-service premiums from our actuarial experience dataset. For the Small Group New York Minimum Loss Ratio pool in 2012, there is no rebate projected. This is based on the 4/1/2013 reports as well as internal projections showing that the MLR is expected to meet the 80% requirement. Therefore, no expected rebates were adjusted out of the premiums.

Allowed and Incurred Claims Incurred During the Experience Period:

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

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

Benefit Categories

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

Projection Factors

Changes in the Morbidity of the Population Insured: The projected change in the morbidity of the population is based on modeling described in further detail in the actuarial memorandum included in the rate filing dated May 15, 2013. It includes the estimated impact of the federal risk adjustment program. The impact of risk adjustment in the 2014 NY small group marketplace was based on the simulation study that was conducted by Deloitte on behalf of DFS. Our own analysis of the block indicates stable morbidity and health status, consistent with the data provided to Deloitte, and we do not expect material changes in 2014. Based on these projections of the market in 2014, this adjustment is -11.2%.

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 10/01/11 through 09/30/12 with run-out through 12/31/12. No adjustments were made for large claims. The historical claims are normalized for demographics, tier, benefit changes, case size, and area to the most recent month of the experience period, and a three month lagged annual experience period weighted average PMPM is calculated and projected forward with trend and seasonality. The medical trend assumptions are based on our small group EPO and MC experience. For this rate filing, we have used 11.8% as the projected change in medical cost.

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

Credibility Manual Rate Development

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

Credibility of Experience

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

Paid to Allowed Ratio

We are projecting the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 71%:

Tier	Projected Membership Distribution	Actuarial Value
Bronze	10.00%	60%
Silver	70.00%	70%
Gold	20.00%	80%
Total	100.00%	71%

Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM:

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

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

Not applicable

Non-Benefit Expenses and Profit & Risk

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

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

1. Taxes and Fees of 5.3% comprised of:
    a. Premium Taxes of 1.6 %
    b. Patient Centered Outcomes Research Fund of $2.00 per member per year, converted to 0.04%
    c. Reinsurance Contribution of $5.12 PMPM, converted to 1.1% based on effective date to account for differences in the contribution level year over year, please see the separate section below
    d. Health Insurer Fee of 2.6% based on effective date to account for differences in the fee level year over year, please see the separate section below

    e. As requested, we did not include any Exchange Fee in the 2014 rate filing
2. Commissions of 6.3% comprised of:
    a. Variable Commissions of 6.3%
3. General Administrative Expenses of 4.0% comprised of Fixed expenses of $19.30, converted to a percentage of premium
4. Risk Charge of 2.0%

Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is 82.8%, not including the credibility adjustment.

Index Rate

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

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

AV Metal Values

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

AV Pricing Values

The fixed reference plan is 17210NY0070000. Benefit factors were developed taking into account the expected benefit category weights and plan cost sharing. No adjustments were made to benefit factors to differentiate based on morbidity differences or benefit selection.

Membership Projections

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

Terminated Products

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

- 17210NY001
- 17210NY002
- 17210NY003

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

Warning Alerts

Total Premium (TP) differs between Worksheets 1 and 2 by $1171, or less than 0.001%. This is due to rounding of premiums and the need to allocate member months and dollars evenly to the plans reported at the product level.

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

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

Actuarial Certification

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

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

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

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

The Part I Unified Rate Review Template does not demonstrate the process used by Aetna to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

[redacted]

_____ May 15, 2013

[redacted], FSA, MAAA

Aetna Life Insurance Company
New York Small Group PPO Filing
SERFF ID: AETN-128993202
Exhibit B

New York Small Group PPO Portfolio | Summary of Benefits

Contents

NY BRONZE OAEPO 2500 100% HSA PY 2
NY BRONZE OAEPO 3500 50% 4
NY BRONZE OAEPO 3500 60% HSA PY 6
NY BRONZE OAEPO 4000 80% 8
NY BRONZE OAEPO 5000 100% HSA PY 10
NY BRONZE OAEPO 5000 60% 12
NY SILVER INDEMNITY 2500 80% 14
NY SILVER OAEPO 2000 60% 16
NY SILVER OAEPO 2000 80% HSA PY 18
NY SILVER OAEPO 2000 90% 20
NY SILVER OAEPO 3000 70% 22
NY SILVER OAMC 2000 80/60 24
NY SILVER OAMC 2000 80/60 HSA PY 26
NY GOLD OAEPO 1000 90% 28
NY BRONZE OAEPO 2500 100% HSA PY RE 30
NY BRONZE OAEPO 3500 50% RE 32
NY BRONZE OAEPO 3500 60% HSA PY RE 34
NY BRONZE OAEPO 4000 80% RE 36
NY BRONZE OAEPO 5000 100% HSA PY RE 38
NY BRONZE OAEPO 5000 60% RE 40
NY SILVER INDEMNITY 2500 80% RE 42
NY SILVER OAEPO 2000 60% RE 44
NY SILVER OAEPO 2000 80% HSA PY RE 46
NY SILVER OAEPO 2000 90% RE 48
NY SILVER OAEPO 3000 70% RE 50
NY SILVER OAMC 2000 80/60 RE 52
NY SILVER OAMC 2000 80/60 HSA PY RE 54
NY GOLD OAEPO 1000 90% RE 56

Summary of Benefits Covered

NY BRONZE OAEPO 2500 100% HSA PY

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$2,500
Family	$5,000
Coinsurance *(Member Responsibility)*	0%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit after deductible
Specialist Visit	$75 per visit after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	$1,000/Admit after deductible
Emergency Room Services	$200 per visit after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$75 per visit after deductible
Imaging (CT/PET Scans, MRIs)	$75 per visit after deductible
Rehabilitative Speech Therapy	$75 per visit after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$75 per visit after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$75 per visit after deductible
X-rays and Diagnostic Imaging	$75 per visit after deductible
Skilled Nursing Facility	$1,000/Admit after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$500 per visit after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible

Pharmacy	In-Network
Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	$10 copay
Preferred Brand Drugs	$55 copay
Non-Preferred Brand Drugs	50% up to $750
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$2,500.00	$2,500.00			
Coinsurance (%, Insurer's Cost Share)	100.00%		100.00%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$50.00	☑	☑		
Specialist Visit	☑	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$75.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$75.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$75.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	76%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	89%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$55.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$55.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.2%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 2500 100% HSA PY, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.2%.

Summary of Benefits Covered

NY BRONZE OAEPO 3500 50%

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$3,500
Family	$7,000
Coinsurance *(Member Responsibility)*	50%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,800
Familiy	$11,600
	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)	50% after deductible
Specialist Visit	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	50% after deductible
Emergency Room Services	50% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	50% after deductible
Imaging (CT/PET Scans, MRIs)	50% after deductible
Rehabilitative Speech Therapy	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	50% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	50% after deductible
X-rays and Diagnostic Imaging	50% after deductible
Skilled Nursing Facility	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	50% after deductible
Outpatient Surgery Physician/Surgical Services	50% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$3,500.00	$3,500.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)	$5,800.00		$5,800.00			
OOP Maximum if Separate ($)	$5,800.00	$0.00				

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.9%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 3500 50%, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.9%.

Summary of Benefits Covered

NY BRONZE OAEPO 3500 60% HSA PY

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$3,500
Family	$7,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	40% after deductible
Specialist Visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	40% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	40% after deductible
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	40% after deductible
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$61.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$3,500.00	$3,500.00			
Coinsurance (%, Insurer's Cost Share)			59.68%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	60%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	60%		☑	☑		
Specialist Visit	☑	☐	60%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	60%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	60%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	60%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	60%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	62.0%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 3500 60% HSA PY, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 62.0%

Summary of Benefits Covered

NY BRONZE OAEPO 4000 80%

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$4,000
Family	$8,000
Coinsurance *(Member Responsibility)*	20%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,000
Familiy	$12,000
	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)	$25 per visit after deductible
Specialist Visit	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible
Emergency Room Services	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible
Rehabilitative Speech Therapy	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible
Skilled Nursing Facility	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$4,000.00	$4,000.00	$4,000.00			
Coinsurance (%, Insurer's Cost Share)			78.99%			
OOP Maximum ($)	$6,000.00		$6,000.00			
OOP Maximum if Separate ($)	$6,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separat
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.3%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 4000 80%, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.3%.

Summary of Benefits Covered

NY BRONZE OAEPO 5000 100% HSA PY

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$5,000
Family	$10,000
Coinsurance *(Member Responsibility)*	0%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	0% after deductible
Specialist Visit	0% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	0% after deductible
Emergency Room Services	0% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	0% after deductible
Imaging (CT/PET Scans, MRIs)	0% after deductible
Rehabilitative Speech Therapy	0% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	0% after deductible
X-rays and Diagnostic Imaging	0% after deductible
Skilled Nursing Facility	0% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$68.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$5,000.00	$5,000.00			
Coinsurance (%, Insurer's Cost Share)	100.00%		100.00%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.7%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 5000 100% HSA PY satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.7%.

Summary of Benefits Covered

NY BRONZE OAEPO 5000 60%

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$5,000
Family	$10,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit
Specialist Visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	40% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	40%
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	40% after deductible
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

Pharmacy	In-Network
Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	$10 copay
Preferred Brand Drugs	50% if no GE available
Non-Preferred Brand Drugs	Not Covered
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$5,000.00	$5,000.00			
Coinsurance (%, Insurer's Cost Share)			58.18%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	60%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☑	☑	60%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	60%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	60%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	60%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	60%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☑	50%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.4%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 5000 60% satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.4%.

Summary of Benefits Covered

NY SILVER INDEMNITY 2500 80%

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible Individual Family		 $2,500 $5,000
Coinsurance *(Member Responsibility)*		20%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum Individual Familiy		 $5,500 $11,000
	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)	$25 per visit after deductible	20% after deductible
Specialist Visit	20% after deductible	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	20% after deductible
Emergency Room Services	20% after deductible	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	20% after deductible
Rehabilitative Speech Therapy	20% after deductible	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	20% after deductible
Preventive Care/Screening/Immunization	0%	0%
Laboratory Outpatient and Professional Services	20% after deductible	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible	20% after deductible
Skilled Nursing Facility	20% after deductible	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	20% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible Individual Family	 N/A N/A	 N/A N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as applicable INN tier cost share + 30%

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	Silver

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

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$2,500.00	$0.00	$2,500.00
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%	
OOP Maximum ($)	$5,500.00		$5,500.00
OOP Maximum if Separate ($)	$5,500.00	$0.00	

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.6%
Metal Tier:	Silver

This product, NY Silver Indemnity 2500 80% satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.6%.

Summary of Benefits Covered

NY SILVER OAEPO 2000 60%

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,500
Familiy	$11,000
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$50 per visit
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	60.00%	50.00%				
OOP Maximum ($)	$5,500.00		$5,500.00			
OOP Maximum if Separate ($)	$5,500.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.8%
Metal Tier:	Silver

This product, NY SILVER OAEPO 2000 60%, satisfies the HHS guidelines a Silver plan with an Actuarial Value of 71.8%

Summary of Benefits Covered

NY SILVER OAEPO 2000 80% HSA PY

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	20%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,000
Familiy	$10,000
	All cost sharing accumulates to the Out of Pocket Maximum above
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	20% after deductible
Specialist Visit	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible
Emergency Room Services	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible
Rehabilitative Speech Therapy	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible
Skilled Nursing Facility	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$262.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$2,000.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)			78.87%			
OOP Maximum ($)	$5,000.00		$5,000.00			
OOP Maximum if Separate ($)	$5,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY Silver OAEPO 2000 80% HSA PY, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%

Summary of Benefits Covered

NY SILVER OAEPO 2000 90%

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible Individual Family	 $2,000 $4,000
Coinsurance *(Member Responsibility)*	10%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum Individual Familiy	 $5,800 $11,600
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	10% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$50 per visit
X-rays and Diagnostic Imaging	10% after deductible
Skilled Nursing Facility	10% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%	
OOP Maximum ($)	$5,800.00		$5,800.00
OOP Maximum if Separate ($)	$5,800.00	$0.00	

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	90%		☑	☑		
Skilled Nursing Facility	☑	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY Silver OAEPO 2000 90% satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%.

Summary of Benefits Covered

NY SILVER OAEPO 3000 70%

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$3,000
Family	$6,000
Coinsurance *(Member Responsibility)*	30%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit
Specialist Visit	$75 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	30% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$75 per visit
Imaging (CT/PET Scans, MRIs)	30% after deductible
Rehabilitative Speech Therapy	$75 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$75 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$75 per visit
X-rays and Diagnostic Imaging	30% after deductible
Skilled Nursing Facility	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% after deductible
Outpatient Surgery Physician/Surgical Services	30% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$0.00	$3,000.00			
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%				
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$75.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	70%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$75.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$75.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	70%		☑	☑		
Skilled Nursing Facility	☑	☑	70%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	70%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	70%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.3%
Metal Tier:	Silver

This product, NY Silver OAEPO 3000 70%, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.3%.

Summary of Benefits Covered

NY SILVER OAMC 2000 80/60

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance *(Member Responsibility)*	20%	40%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$6,000	$12,000
Familiy	$12,000	$24,000
	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)	$40 per visit	40% after deductible
Specialist Visit	$60 per visit after deductible	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	40% after deductible
Emergency Room Services	$200 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$60 per visit	40% after deductible
Imaging (CT/PET Scans, MRIs)	$60 per visit after deductible	40% after deductible
Rehabilitative Speech Therapy	$60 per visit after deductible	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$60 per visit after deductible	40% after deductible
Preventive Care/Screening/Immunization	0%	40% after deductible
Laboratory Outpatient and Professional Services	$60 per visit after deductible	40% after deductible
X-rays and Diagnostic Imaging	$60 per visit after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 copay + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as INN applicable tier cost share + 30%

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?	☐
e Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%				
OOP Maximum ($)	$6,000.00		$6,000.00			
OOP Maximum if Separate ($)	$6,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$60.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$60.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$60.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$60.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$60.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$60.00	☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
gin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.8%
Metal Tier:	Silver

This product, NY Silver OAMC 2000 80/60 satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.8%

Summary of Benefits Covered

NY SILVER OAMC 2000 80/60 HSA PY

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance *(Member Responsibility)*	20%	40%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$5,000	$10,000
Familiy	$10,000	$20,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	20% after deductible	40% after deductible
Specialist Visit	20% after deductible	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	40% after deductible
Emergency Room Services	20% after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible	40% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	40% after deductible
Rehabilitative Speech Therapy	20% after deductible	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	40% after deductible
Preventive Care/Screening/Immunization	0%	40% after deductible
Laboratory Outpatient and Professional Services	20% after deductible	40% after deductible
X-rays and Diagnostic Imaging	20% after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 copay + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as applicable INN tier cost share + 30%

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?	☐
e Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☑
Annual Contribution Amount:	$262.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$2,000.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)			78.87%			
OOP Maximum ($)	$5,000.00		$5,000.00			
OOP Maximum if Separate ($)	$5,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
gin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY SILVER OAMC 2000 80/60 HSA PY, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%

Summary of Benefits Covered

NY GOLD OAEPO 1000 90%

New York Small Group

Gold Plan

Summary of Features	In-Network
Deductible	
Individual	$1,000
Family	$2,000
Coinsurance *(Member Responsibility)*	10%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$3,000
Familiy	$6,000
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible
Emergency Room Services	$150 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	10% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	10% after deductible
X-rays and Diagnostic Imaging	10% after deductible
Skilled Nursing Facility	10% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00	$1,000.00			
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%				
OOP Maximum ($)	$3,000.00		$3,000.00			
OOP Maximum if Separate ($)	$3,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☐	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	90%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	90%		☑	☑		
Skilled Nursing Facility	☑	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.3%
Metal Tier:	Gold

This product, NY Gold OAEPO 1000 90%, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.3%.

Summary of Benefits Covered

NY BRONZE OAEPO 2500 100% HSA PY RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible Individual Family	 $2,500 $5,000
Coinsurance *(Member Responsibility)*	0%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum Individual Familiy	 $6,250 $12,500
	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)	$50 per visit after deductible
Specialist Visit	$75 per visit after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	$1,000/Admit after deductible
Emergency Room Services	$200 per visit after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$75 per visit after deductible
Imaging (CT/PET Scans, MRIs)	$75 per visit after deductible
Rehabilitative Speech Therapy	$75 per visit after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$75 per visit after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$75 per visit after deductible
X-rays and Diagnostic Imaging	$75 per visit after deductible
Skilled Nursing Facility	$1,000/Admit after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$500 per visit after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible

Pharmacy	In-Network
Pharmacy Deductible Individual Family	 N/A N/A
Generics	$10 copay
Preferred Brand Drugs	$55 copay
Non-Preferred Brand Drugs	50% up to $750
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$2,500.00	$2,500.00	$2,500.00
Coinsurance (%, Insurer's Cost Share)	100.00%		100.00%
OOP Maximum ($)	$6,250.00		$6,250.00
OOP Maximum if Separate ($)	$6,250.00	$0.00	

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$50.00	☑	☑		
Specialist Visit	☑	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$75.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$75.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$75.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	76%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	89%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$55.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$55.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.2%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 2500 100% HSA PY RE, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.2%.

Summary of Benefits Covered

NY BRONZE OAEPO 3500 50% RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible Individual Family	 $3,500 $7,000
Coinsurance *(Member Responsibility)*	50%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum Individual Familiy	 $5,800 $11,600
	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)	50% after deductible
Specialist Visit	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	50% after deductible
Emergency Room Services	50% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	50% after deductible
Imaging (CT/PET Scans, MRIs)	50% after deductible
Rehabilitative Speech Therapy	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	50% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	50% after deductible
X-rays and Diagnostic Imaging	50% after deductible
Skilled Nursing Facility	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	50% after deductible
Outpatient Surgery Physician/Surgical Services	50% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$3,500.00	$3,500.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)	$5,800.00		$5,800.00			
OOP Maximum if Separate ($)	$5,800.00	$0.00				

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.9%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 3500 50% RE, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.9%.

Summary of Benefits Covered

NY BRONZE OAEPO 3500 60% HSA PY RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible Individual Family	 $3,500 $7,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum Individual Familiy	 $6,250 $12,500
	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)	40% after deductible
Specialist Visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	40% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	40% after deductible
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	40% after deductible
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$61.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$3,500.00	$3,500.00			
Coinsurance (%, Insurer's Cost Share)			59.68%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	60%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	60%		☑	☑		
Specialist Visit	☑	☐	60%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	60%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	60%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	60%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	60%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	62.0%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 3500 60% HSA PY RE, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 62.0%

Summary of Benefits Covered

NY BRONZE OAEPO 4000 80% RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$4,000
Family	$8,000
Coinsurance *(Member Responsibility)*	20%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,000
Familiy	$12,000
	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)	$25 per visit after deductible
Specialist Visit	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible
Emergency Room Services	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible
Rehabilitative Speech Therapy	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible
Skilled Nursing Facility	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$4,000.00	$4,000.00	$4,000.00			
Coinsurance (%, Insurer's Cost Share)			78.99%			
OOP Maximum ($)	$6,000.00		$6,000.00			
OOP Maximum if Separate ($)	$6,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separat
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.3%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 4000 80% RE, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.3%.

Summary of Benefits Covered

NY BRONZE OAEPO 5000 100% HSA PY RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible Individual Family	 $5,000 $10,000
Coinsurance *(Member Responsibility)*	0% *$0 once out-of-pocket max. is satisfied*
Out-of-Pocket Maximum Individual Familiy	 $6,250 $12,500 *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)	0% after deductible
Specialist Visit	0% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	0% after deductible
Emergency Room Services	0% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	0% after deductible
Imaging (CT/PET Scans, MRIs)	0% after deductible
Rehabilitative Speech Therapy	0% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	0% after deductible
X-rays and Diagnostic Imaging	0% after deductible
Skilled Nursing Facility	0% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$68.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$5,000.00	$5,000.00			
Coinsurance (%, Insurer's Cost Share)	100.00%		100.00%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

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

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.7%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 5000 100% HSA PY RE satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.7%.

Summary of Benefits Covered

NY BRONZE OAEPO 5000 60% RE

New York Small Group

Bronze Plan

Summary of Features	In-Network
Deductible	
Individual	$5,000
Family	$10,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit
Specialist Visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	40% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	40%
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	40% after deductible
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

Pharmacy	In-Network
Pharmacy Deductible	
Individual	N/A
Family	N/A
Generics	$10 copay
Preferred Brand Drugs	50% if no GE available
Non-Preferred Brand Drugs	Not Covered
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$5,000.00	$5,000.00			
Coinsurance (%, Insurer's Cost Share)			58.18%			
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	60%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☑	☑	60%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	60%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	60%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	60%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	60%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☑	50%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.4%
Metal Tier:	Bronze

This product, NY Bronze OAEPO 5000 60% RE satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.4%.

Summary of Benefits Covered

NY SILVER INDEMNITY 2500 80% RE

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual		$2,500
Family		$5,000
Coinsurance *(Member Responsibility)*		20%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual		$5,500
Familiy		$11,000
	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)	$25 per visit after deductible	20% after deductible
Specialist Visit	20% after deductible	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	20% after deductible
Emergency Room Services	20% after deductible	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	20% after deductible
Rehabilitative Speech Therapy	20% after deductible	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	20% after deductible
Preventive Care/Screening/Immunization	0%	0%
Laboratory Outpatient and Professional Services	20% after deductible	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible	20% after deductible
Skilled Nursing Facility	20% after deductible	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	20% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as applicable INN tier cost share + 30%

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	Silver

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$0.00	$2,500.00			
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%				
OOP Maximum ($)	$5,500.00		$5,500.00			
OOP Maximum if Separate ($)	$5,500.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.6%
Metal Tier:	Silver

This product, NY Silver Indemnity 2500 80% RE satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.6%.

Summary of Benefits Covered

NY SILVER OAEPO 2000 60% RE

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	40%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,500
Familiy	$11,000
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	40% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$50 per visit
X-rays and Diagnostic Imaging	40% after deductible
Skilled Nursing Facility	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	60.00%	50.00%				
OOP Maximum ($)	$5,500.00		$5,500.00			
OOP Maximum if Separate ($)	$5,500.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	60%		☑	☑		
Skilled Nursing Facility	☑	☑	60%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	60%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.8%
Metal Tier:	Silver

This product, NY SILVER OAEPO 2000 60% RE, satisfies the HHS guidelines a Silver plan with an Actuarial Value of 71.8%

Summary of Benefits Covered

NY SILVER OAEPO 2000 80% HSA PY RE

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	20%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,000
Familiy	$10,000
	All cost sharing accumulates to the Out of Pocket Maximum above
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	20% after deductible
Specialist Visit	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible
Emergency Room Services	20% after deductible
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible
Rehabilitative Speech Therapy	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	20% after deductible
X-rays and Diagnostic Imaging	20% after deductible
Skilled Nursing Facility	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan? ☐
Annual Contribution Amount:	$262.00	1st Tier Utilization:
		2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$2,000.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)			78.87%			
OOP Maximum ($)	$5,000.00		$5,000.00			
OOP Maximum if Separate ($)	$5,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY Silver OAEPO 2000 80% HSA PY RE, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%

Summary of Benefits Covered

NY SILVER OAEPO 2000 90% RE

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$2,000
Family	$4,000
Coinsurance *(Member Responsibility)*	10%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$5,800
Familiy	$11,600
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	10% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$50 per visit
X-rays and Diagnostic Imaging	10% after deductible
Skilled Nursing Facility	10% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%				
OOP Maximum ($)	$5,800.00		$5,800.00			
OOP Maximum if Separate ($)	$5,800.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	90%		☑	☑		
Skilled Nursing Facility	☑	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY Silver OAEPO 2000 90% RE satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%.

Summary of Benefits Covered

NY SILVER OAEPO 3000 70% RE

New York Small Group

Silver Plan

Summary of Features	In-Network
Deductible	
Individual	$3,000
Family	$6,000
Coinsurance *(Member Responsibility)*	30%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$6,250
Familiy	$12,500
	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)	$50 per visit
Specialist Visit	$75 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	30% after deductible
Emergency Room Services	$200 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$75 per visit
Imaging (CT/PET Scans, MRIs)	30% after deductible
Rehabilitative Speech Therapy	$75 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$75 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	$75 per visit
X-rays and Diagnostic Imaging	30% after deductible
Skilled Nursing Facility	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% after deductible
Outpatient Surgery Physician/Surgical Services	30% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$0.00	$3,000.00			
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%				
OOP Maximum ($)	$6,250.00		$6,250.00			
OOP Maximum if Separate ($)	$6,250.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible? ☐ All	Tier 1 Subject to Coinsurance ☐ All	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible ☑ All	Tier 2 Subject to Coinsurance ☑ All	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical								
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$75.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	70%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$75.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$75.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑	70%		☑	☑		
Skilled Nursing Facility	☑	☑	70%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	70%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	70%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.3%
Metal Tier:	Silver

This product, NY Silver OAEPO 3000 70% RE, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.3%.

Summary of Benefits Covered

NY SILVER OAMC 2000 80/60 RE

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance *(Member Responsibility)*	20%	40%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$6,000	$12,000
Familiy	$12,000	$24,000
	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)	$40 per visit	40% after deductible
Specialist Visit	$60 per visit after deductible	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	40% after deductible
Emergency Room Services	$200 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$60 per visit	40% after deductible
Imaging (CT/PET Scans, MRIs)	$60 per visit after deductible	40% after deductible
Rehabilitative Speech Therapy	$60 per visit after deductible	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$60 per visit after deductible	40% after deductible
Preventive Care/Screening/Immunization	0%	40% after deductible
Laboratory Outpatient and Professional Services	$60 per visit after deductible	40% after deductible
X-rays and Diagnostic Imaging	$60 per visit after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 copay + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as INN applicable tier cost share + 30%

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?	☐
e Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%				
OOP Maximum ($)	$6,000.00		$6,000.00			
OOP Maximum if Separate ($)	$6,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$60.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$60.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$60.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$60.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$60.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$60.00	☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
gin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.8%
Metal Tier:	Silver

This product, NY Silver OAMC 2000 80/60 RE satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.8%

Summary of Benefits Covered

NY SILVER OAMC 2000 80/60 HSA PY RE

New York Small Group

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance *(Member Responsibility)*	20%	40%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$5,000	$10,000
Familiy	$10,000	$20,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	20% after deductible	40% after deductible
Specialist Visit	20% after deductible	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	20% after deductible	40% after deductible
Emergency Room Services	20% after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	20% after deductible	40% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	40% after deductible
Rehabilitative Speech Therapy	20% after deductible	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	40% after deductible
Preventive Care/Screening/Immunization	0%	40% after deductible
Laboratory Outpatient and Professional Services	20% after deductible	40% after deductible
X-rays and Diagnostic Imaging	20% after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	$10 copay	$10 copay + 30%
Preferred Brand Drugs	$50 copay	$50 copay + 30%
Non-Preferred Brand Drugs	50% up to $750	50% up to $750 + 30%
Specialty Drugs (i.e. high-cost)	Same as applicable tier cost share.	Same as applicable INN tier cost share + 30%

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?	☐
e Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☑
Annual Contribution Amount:	$262.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$2,000.00	$2,000.00			
Coinsurance (%, Insurer's Cost Share)			78.87%			
OOP Maximum ($)	$5,000.00		$5,000.00			
OOP Maximum if Separate ($)	$5,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑		
Specialist Visit	☑	☑	80%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	80%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	80%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	80%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑		
Skilled Nursing Facility	☑	☑	80%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
gin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

This product, NY SILVER OAMC 2000 80/60 HSA PY RE, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.0%

Summary of Benefits Covered

NY GOLD OAEPO 1000 90% RE

New York Small Group

Gold Plan

Summary of Features	In-Network
Deductible	
Individual	$1,000
Family	$2,000
Coinsurance *(Member Responsibility)*	10%
	$0 once out-of-pocket max. is satisfied
Out-of-Pocket Maximum	
Individual	$3,000
Familiy	$6,000
	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)	$30 per visit
Specialist Visit	$50 per visit
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible
Emergency Room Services	$150 per visit
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$50 per visit
Imaging (CT/PET Scans, MRIs)	10% after deductible
Rehabilitative Speech Therapy	$50 per visit
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit
Preventive Care/Screening/Immunization	0%
Laboratory Outpatient and Professional Services	10% after deductible
X-rays and Diagnostic Imaging	10% after deductible
Skilled Nursing Facility	10% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible

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

Actuarial Value Snapshot

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

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00	$1,000.00			
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%				
OOP Maximum ($)	$3,000.00		$3,000.00			
OOP Maximum if Separate ($)	$3,000.00	$0.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
	☐ All	☐ All			☑ All	☑ All		
Medical								
Emergency Room Services	☐	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	90%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	90%		☑	☑		
Skilled Nursing Facility	☑	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$50.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? ☑
Specialty Rx Coinsurance Maximum: $750

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

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

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

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 79.3%
Metal Tier: Gold

This product, NY Gold OAEPO 1000 90% RE, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.3%.

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:

Aetna Life Insurance Company	A&H - 42	For Profit	60054
Company submitting the rate adjustment request	Company Type	Org. Type	Company NAIC Code

151 Farmington Ave.
Hartford, CT 06156
Company mailing address

B. Contact Person:

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

C. Actuarial Contact (If different from above):

[redacted] Actuary	([redacted]	[redacted]
Actuary name, title	Actuary phone number	Actuary Email address

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

January 1, 2014 to December 31, 2014	01/01/2014	AETN-128993202
New rate applicability period	New rate effective date	SERFF Tracking Number

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

F. Provide responses for the following questions:

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

Notes:

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

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

Use the following SERFF filing types for rate adjustment filings:

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

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

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

Company Name: Aetna Life Insurance Company
NAIC Code: 60054
SERFF Number: AETN-128993202
Market Segment: SG

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). Use the drop down list to enter the market segment.

D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans and Base+Supplemental. Indicate appropriate designation for policy form, etc.

E. The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Include a region identifier in this column if needed.

F. Note that many cells include a drop down list. Use the drop down list for entries.

G. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).

H. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identifier	3. Effective date of rate change (MM/DD/YY)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change (For group business this is number of groups.)	9. Number of covered lives affected by rate change
	EPO MC Indemnity	EPO MC Indemnity	SG ALIC	1/1/14	SG	EPO	Yes	Open	4,316	31,301

Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)									
14.1 Beginning Date of the experience period (MM/DD/YY)	14.2 Ending Date of the experience period (MM/DD/YY)	14.3 Member months for experience period	14.4 Earned premiums for experience period ($)	14.5 Standardized earned premiums for experience period ($)	14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	14.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool ($)	14.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) ($)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)
10/01/11	09/30/12	348,588	154,554,981	183,805,172	124,950,065	126,494,889	0	(806,828)	20,400,865

First 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) ($)
10/01/10	09/30/11	339,882	141,283,338	185,737,380	114,038,465	114,105,405	0	(5,170,815)	18,649,042

Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										
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) ($)	
10/01/09	09/30/10	535,806	205,571,159	336,292,042	188,066,691	188,123,463	0	(11,264,000)	27,134,871	XX

Exhibit 7A: Calculation of Standardized Premium

Calculation of Standardized Premium

Premium PMPM

Cohort	DOS Month Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
Jan	347.72	346.17	346.13	343.25	367.57	370.54	370.88	371.17	369.67	369.54	369.69	369.82	369.45	370.24	370.10
Feb	358.20	356.91	357.48	355.29	352.40	378.78	377.89	379.95	380.00	378.96	379.88	380.56	379.31	382.25	383.96
Mar	368.14	368.19	369.15	370.46	370.14	375.37	390.41	391.53	388.75	388.30	390.33	389.78	386.69	387.28	387.07
Apr	382.10	382.32	380.99	381.56	381.65	381.62	383.16	413.20	418.51	417.58	418.15	419.15	417.92	418.00	417.88
May	373.55	373.09	372.77	371.59	372.49	371.14	370.89	401.71	405.33	408.35	407.61	409.23	408.46	410.90	411.28
Jun	376.18	375.93	376.91	377.45	377.12	377.03	378.44	377.59	409.94	411.39	414.85	414.50	412.71	413.97	412.69
Jul	398.11	399.06	398.43	397.02	396.41	396.01	398.00	398.86	398.74	404.50	413.26	419.74	418.93	417.84	422.73
Aug	400.51	400.56	398.25	397.31	395.69	394.55	392.69	390.96	389.39	388.16	395.77	421.91	421.27	420.41	420.20
Sep	380.35	378.67	376.34	370.81	377.25	377.72	376.86	373.94	373.49	373.66	372.96	400.89	398.83	407.81	408.70
Oct	415.22	413.60	413.87	412.91	408.70	407.45	405.71	404.76	402.71	403.26	403.71	403.81	404.35	408.49	407.55
Nov	373.29	417.40	414.49	417.74	418.54	418.75	415.91	416.16	416.09	413.25	414.30	416.62	414.07	410.17	411.98
Dec	371.28	371.39	382.09	367.72	394.04	392.97	389.97	391.48	391.51	390.19	389.65	391.41	391.83	391.31	409.80
Tot	374.37	375.88	376.16	376.25	381.16	383.66	384.99	389.35	393.00	392.85	394.30	399.75	398.39	399.37	401.62

Cohort	0 Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Jan	413.24	422.50	421.67	420.96	419.85	421.67	420.26	422.04	422.04	425.78	422.92	423.46	442.60	443.33	443.85	442.29	443.58	444.56	445.62	445.47	450.42
Feb	379.67	427.17	430.57	430.32	430.71	430.94	431.07	430.45	430.96	431.50	431.00	431.87	426.47	444.68	444.04	442.50	445.46	444.79	443.65	442.90	444.45
Mar	389.23	421.91	427.99	425.75	427.47	428.05	426.67	427.21	429.78	424.17	424.67	427.01	428.35	449.63	448.10	451.30	450.90	452.43	451.17	457.52
Apr	416.05	415.78	416.16	443.30	445.97	445.98	443.98	443.90	444.86	446.33	444.18	446.15	441.64	442.64	442.95	464.59	464.29	464.99	466.44	466.18	469.79
May	409.77	408.76	408.56	407.16	463.28	444.11	449.49	452.35	446.57	442.70	444.40	444.84	443.72	443.76	443.42	442.21	452.46	457.58	462.09	458.05	462.29
Jun	416.06	417.82	416.36	414.92	415.41	449.91	450.49	447.42	446.70	447.66	447.90	448.47	448.09	447.27	449.19	445.92	447.19	466.74	472.23	473.43	475.34
Jul	422.83	421.75	422.29	421.41	420.09	418.93	451.99	449.77	450.69	447.87	448.35	448.68	448.40	447.57	449.63	448.47	449.40	448.34	478.96	479.87	482.22
Aug	421.05	420.78	421.81	420.56	419.82	419.58	422.48	449.38	450.62	460.51	454.03	453.41	454.87	449.85	450.11	449.02	448.62	448.90	450.27	459.30	464.56
Sep	405.67	406.15	404.21	405.09	405.36	402.29	400.58	401.73	426.72	429.48	429.08	429.77	429.07	428.52	429.49	427.02	427.70	428.95	428.72	428.10	446.62
Oct	409.90	409.99	409.87	408.32	406.12	405.84	405.13	404.06	403.43	435.72	436.70	436.01	432.27	429.63	432.03	424.75	431.03	432.68	432.51	431.63	431.83
Nov	416.71	415.48	416.12	417.21	415.41	417.22	417.77	418.89	418.46	420.41	434.10	442.95	444.14	444.81	444.82	443.80	447.47	445.24	447.67	447.30	446.58
Dec	411.79	409.92	411.20	410.16	410.34	413.17	408.67	408.60	405.51	412.78	409.65	434.40	434.85	431.89	435.61	432.99	435.74	434.87	434.92	433.03	433.47
Tot	407.45	412.61	417.22	419.56	423.90	426.25	427.80	429.39	430.73	434.55	433.49	436.52	438.59	439.56	443.05	442.78	445.39	447.77	450.79	450.65	454.77

Member Months

Cohort	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
Jan	8,039	7,994	7,824	4,579	4,377	4,297	4,275	4,274	4,174	4,082	4,024	3,996	4,000	3,978	3,821
Feb	4,559	4,554	4,518	4,266	2,788	2,536	2,486	2,447	2,445	2,416	2,380	2,392	2,373	2,322	2,277
Mar	6,709	6,639	6,627	6,503	6,498	4,614	4,431	4,359	4,274	4,260	4,223	4,128	4,089	4,077	4,071
Apr	4,724	4,690	4,632	4,529	4,442	4,283	2,755	2,584	2,422	2,353	2,316	2,312	2,270	2,255	2,232
May	4,925	4,884	4,830	4,768	4,727	4,714	4,610	2,623	2,745	2,671	2,622	2,451	2,418	2,393	2,377
Jun	6,740	6,696	6,697	6,617	6,540	6,452	6,345	6,288	3,496	3,321	3,121	3,088	3,035	2,991	2,925
Jul	3,253	3,220	3,235	3,151	3,164	3,117	3,074	3,043	2,938	1,818	1,710	1,674	1,679	1,664	1,554
Aug	3,068	3,035	2,991	2,945	2,925	2,892	2,870	2,852	2,831	2,804	1,918	1,734	1,710	1,697	1,685
Sep	4,566	4,585	4,444	4,337	4,317	4,307	4,297	4,336	4,322	4,282	4,225	2,720	2,579	2,507	2,465
Oct	2,850	2,638	2,577	2,516	2,422	2,390	2,366	2,366	2,371	2,329	2,314	2,307	1,721	1,531	1,509
Nov	3,131	2,758	2,533	2,474	2,425	2,380	2,322	2,264	2,264	2,250	2,261	2,210	2,183	1,632	1,575
Dec	4,063	4,022	3,632	3,535	3,522	3,518	3,495	3,471	3,467	3,455	3,468	3,440	3,435	3,400	2,616
BoB	56,627	55,715	54,540	50,220	48,147	45,500	43,326	40,907	37,749	36,041	34,582	32,452	31,492	30,447	29,107

Cohort	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Jan	3,861	3,686	3,670	3,648	3,611	3,575	3,535	3,524	3,532	3,501	3,507	3,498	5,210	5,141	5,105	5,087	5,037	5,008	4,981	4,954	4,809
Feb	2,223	2,520	2,418	2,359	2,289	2,267	2,260	2,225	2,220	2,213	2,192	2,197	2,171	2,846	2,825	2,819	2,791	2,747	2,715	2,679	2,667
Mar	3,971	3,895	3,880	3,785	3,801	3,738	3,742	3,756	3,756	3,766	3,759	3,747	3,523	3,446	3,824	3,760	3,676	3,645	3,653	3,610	3,586
Apr	2,120	2,103	2,029	2,125	2,066	2,012	1,974	1,941	1,913	1,873	1,864	1,868	1,827	1,819	1,805	2,314	2,298	2,277	2,260	2,261	2,241
May	2,346	2,302	2,291	2,270	2,418	2,330	2,305	2,261	2,230	2,192	2,154	2,144	2,037	2,023	1,985	1,947	2,278	2,267	2,248	2,242	2,242
Jun	2,857	2,829	2,823	2,793	2,748	2,853	2,741	2,755	2,740	2,729	2,685	2,666	2,622	2,503	2,466	2,453	2,427	2,880	2,870	2,833	2,824
Jul	1,496	1,456	1,441	1,443	1,424	1,375	1,476	1,464	1,461	1,445	1,426	1,407	1,327	1,296	1,276	1,253	1,244	1,217	1,519	1,515	1,494
Aug	1,676	1,661	1,644	1,635	1,604	1,586	1,553	1,676	1,649	1,616	1,632	1,654	1,602	1,556	1,544	1,522	1,520	1,500	1,482	1,867	1,832
Sep	2,401	2,390	2,314	2,306	2,274	2,233	2,228	2,172	2,468	2,426	2,386	2,364	2,326	2,304	2,294	2,272	2,261	2,232	2,180	2,164	2,761
Oct	1,490	1,478	1,462	1,445	1,433	1,398	1,386	1,367	1,348	1,618	1,619	1,599	1,602	1,631	1,611	1,587	1,577	1,527	1,523	1,510	1,498
Nov	1,564	1,547	1,528	1,536	1,546	1,505	1,499	1,481	1,490	1,447	1,725	1,657	1,674	1,680	1,692	1,691	1,647	1,630	1,628	1,625	1,614
Dec	2,547	2,476	2,461	2,439	2,426	2,407	2,416	2,365	2,368	2,327	2,305	3,014	2,919	2,912	2,842	2,838	2,828	2,826	2,783	2,782	2,765
BoB	28,552	28,343	27,961	27,784	27,640	27,279	27,115	26,987	27,175	27,153	27,254	27,815	28,840	29,157	29,269	29,543	29,584	29,756	29,842	30,042	30,333

Cumulative Rate Increase

Cohort	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
Jan	1.928	1.928	1.928	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458
Feb	1.928	1.928	1.928	1.928	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458
Mar	1.928	1.928	1.928	1.928	1.928	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458	1.458
Apr	1.819	1.819	1.819	1.819	1.819	1.819	1.363	1.363	1.363	1.363	1.363	1.363	1.363	1.363	1.363
May	1.819	1.819	1.819	1.819	1.819	1.819	1.819	1.363	1.363	1.363	1.363	1.363	1.363	1.363	1.363
Jun	1.819	1.819	1.819	1.819	1.819	1.819	1.819	1.819	1.363	1.363	1.363	1.363	1.363	1.363	1.363
Jul	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.300	1.300	1.300	1.300	1.300	1.300
Aug	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.300	1.300	1.300	1.300	1.300
Sep	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.607	1.300	1.300	1.300	1.300
Oct	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.300	1.300	1.300
Nov	1.985	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.300
Dec	1.985	1.985	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.531	1.300

Cohort	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Jan	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.161	1.161	1.161	1.161	1.161	1.161	1.161	1.161	1.161
Feb	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.161	1.161	1.161	1.161	1.161	1.161	1.161	1.161
Mar	1.458	1.458	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.268	1.161	1.161	1.161	1.161	1.161	1.161	1.161
Apr	1.363	1.363	1.363	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.127	1.127	1.127	1.127	1.127	1.127
May	1.363	1.363	1.363	1.363	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.127	1.127	1.127	1.127	1.127
Jun	1.363	1.363	1.363	1.363	1.363	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.231	1.127	1.127	1.127	1.127
Jul	1.300	1.300	1.300	1.300	1.300	1.300	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.094	1.094	1.094
Aug	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.094	1.094
Sep	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.094
Oct	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195
Nov	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195
Dec	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.300	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195	1.195

claims	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
	21243006.37	18818971.9	18734852	16787443.9	16906583	17085803.6	15646278	14127214	14380312	12234437	11928955	10229606

claims	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
	10972569	10226830	8781739.9	10062924	8870362.5	9593565.7	9249439	10005851	9179721.7	8654265.4	9625329	8882808.7

claims	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
	9573341.1	10473943	9644510.6	10819035	12006238	10355034	10392559	11005908	10250305	11108243	10847611	10018161

Historical Rate Increases

QTR	QRTLY	to Dec '13
4Q07	1.063	2.356
1Q08	1.041	2.264
2Q08	1.046	2.164
3Q08	1.046	2.069
4Q08	1.042	1.985
1Q09	1.030	1.928
2Q09	1.060	1.819
3Q09	1.131	1.607
4Q09	1.050	1.531
1Q10	1.050	1.458
2Q10	1.070	1.363
3Q10	1.048	1.300
4Q10	1.000	1.300
1Q11	1.025	1.268
2Q11	1.030	1.231
3Q11	1.030	1.195
4Q11	1.000	1.195
1Q12	1.030	1.161
2Q12	1.030	1.127
3Q12	1.030	1.094
4Q12	1.000	1.094
1Q13	1.010	1.083
2Q13	1.027	1.055
Jul-13	1.027	1.027
Aug-13	1.000	1.027
Sep-13	1.000	1.027
Oct-13	1.027	1.000
Nov-13	1.000	1.000
Dec-13	1.000	**1.000**
1Q14	1.000	
2Q14	1.025	
3Q14	1.025	
4Q14	1.025	

	Billed Premium*	Std Premium**	Std/Billed
10/2009-09/2010	205,571,159	336,292,042	1.636
10/2010-09/2011	141,283,338	185,737,380	1.315
10/2011-09/2012	154,554,981	183,805,172	1.189

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

Aetna Life Insurance Company
New York Small Group

Month/Year Incurred	Membership	Normalized Medical Claims PMPM 1-Month	Normalized Medical Claims PMPM 12-Month Rolling	Annualized Medical Trend 12-Month Rolling
Jan-10	2,948	231.67		
Feb-10	3,011	198.79		
Mar-10	3,154	273.05		
Apr-10	3,274	237.77		
May-10	3,419	253.62		
Jun-10	3,550	311.65		
Jul-10	3,562	279.98		
Aug-10	3,728	297.39		
Sep-10	3,790	272.16		
Oct-10	3,928	274.87		
Nov-10	4,101	218.18		
Dec-10	4,441	238.53	257.91	
Jan-11	4,561	207.51	254.48	
Feb-11	4,702	196.67	252.23	
Mar-11	4,857	242.14	249.83	
Apr-11	5,081	214.19	246.99	
May-11	5,175	243.58	246.20	
Jun-11	5,479	259.18	243.19	
Jul-11	5,405	223.48	238.89	
Aug-11	5,418	256.90	236.77	
Sep-11	5,564	223.52	233.23	
Oct-11	5,608	274.12	234.32	
Nov-11	5,821	227.19	234.72	
Dec-11	6,051	228.37	233.85	-9.3%
Jan-12	6,503	254.93	237.76	-6.6%
Feb-12	7,034	198.67	236.56	-6.2%
Mar-12	7,662	289.03	241.86	-3.2%
Apr-12	8,163	225.46	241.95	-2.0%
May-12	8,615	278.30	245.89	-0.1%
Jun-12	9,199	269.71	247.69	1.9%
Jul-12	9,653	259.28	250.54	4.9%
Aug-12	10,183	308.29	256.69	8.4%
Sep-12	10,862	221.89	254.66	9.2%
Oct-12	11,236	267.21	254.97	8.8%
Nov-12	11,601	230.49	253.83	8.1%
Dec-12	12,110	240.29	253.74	8.5%
			Average Last 6 with 1 month lag:	***6.9%***
			Trend Pick:	10.3%

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

Aetna Life Insurance Company
New York Small Group

Month/Year Incurred	Membership	Normalized Medical Claims PMPM 1-Month	Normalized Medical Claims PMPM 12-Month Rolling	Annualized Medical Trend 12-Month Rolling
Jan-10	50,220	270.07		
Feb-10	48,147	286.53		
Mar-10	45,500	314.00		
Apr-10	43,326	306.27		
May-10	40,907	295.99		
Jun-10	37,749	334.99		
Jul-10	36,041	301.78		
Aug-10	34,582	308.63		
Sep-10	32,452	283.45		
Oct-10	31,492	316.03		
Nov-10	30,447	307.80		
Dec-10	29,107	279.19	299.73	
Jan-11	28,552	326.64	304.88	
Feb-11	28,343	290.84	306.04	
Mar-11	27,961	322.29	306.27	
Apr-11	27,784	314.16	306.84	
May-11	27,640	342.57	310.69	
Jun-11	27,279	319.57	308.82	
Jul-11	27,115	303.60	309.14	
Aug-11	26,987	339.15	311.54	
Sep-11	27,175	312.58	314.30	
Oct-11	27,153	337.47	316.01	
Nov-11	27,254	369.45	321.15	
Dec-11	27,815	334.64	325.97	8.8%
Jan-12	28,840	365.16	329.32	8.0%
Feb-12	29,157	402.79	339.06	10.8%
Mar-12	29,269	347.68	341.22	11.4%
Apr-12	29,543	346.76	343.95	12.1%
May-12	29,584	366.95	346.08	11.4%
Jun-12	29,756	340.31	347.71	12.6%
Jul-12	29,842	367.84	352.95	14.2%
Aug-12	30,042	357.75	354.45	13.8%
Sep-12	30,333	328.17	355.43	13.1%
Oct-12	30,746	344.87	355.89	12.6%
Nov-12	31,036	346.68	354.05	10.2%
Dec-12	31,719	381.26	357.95	9.8%
			Average Last 6 with 3 month lag:	***12.9%***
			Trend Pick:	11.8%

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

Aetna Life Insurance Company
New York Small Group

Exhibit 7C: Large Group Trend HMO

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

Historical Average Trend	10.3%

Aetna Life Insurance Company
New York Small Group

Exhibit 7D: Unit Cost Trend

Line Of Business	Product	Reimbursement Type	DOS	FI Only
CP	ACAS	ALL	Mar-13	0.00%

	Reimb. Type Facility	2012 Latest Estimate	2013 Latest Estimate	2014 Latest Estimate	Average Estimate
New York	Total	6.68%	5.67%	6.49%	6.49%

	Reimb. Type Physician	2012 Latest Estimate	2013 Latest Estimate	2014 Latest Estimate	Average Estimate
New York	Total	0.67%	1.40%	1.49%	1.49%

	Reimb. Type Total	2012 Latest Estimate	2013 Latest Estimate	2014 Latest Estimate	Average Estimate
New York	Total	3.73%	3.63%	4.16%	4.16%

Weights

Facility:	55%
Physician:	45%

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Aetna Life Insurance Company
NAIC Code: 60054
SERFF Number: AETN-128993202
Market Segment: SG

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

Line #	General																																
1	Product*		ElectChoiceOpenAcces	ManagedChoiceOpenA	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ElectChoiceOpenAcces	ManagedChoiceOpenA	Indemnity	ElectChoiceOpenAccess	ManagedChoiceOpenAc	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ElectChoiceOpenAccess	ManagedChoiceOpenAc	Indemnity
2	Product ID*		17210NY009	17210NY007	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY007	17210NY008	17210NY009	17210NY007	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY009	17210NY007	17210NY008
3	Metal Level (or catastrophic)*		Gold	Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Silver	Bronze	Bronze	Silver	Silver	Gold	Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Silver	Bronze	Bronze	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*		0.7934	0.6884	0.7199	0.7176	0.6830	0.6192	0.6125	0.6138	0.6123	0.7200	0.6200	0.6171	0.7200	0.6860	0.7934	0.6884	0.7199	0.7176	0.6830	0.6192	0.6125	0.6138	0.6123	0.7200	0.6200	0.6171	0.7200	0.6860	0.7934	0.6884
5	AV Pricing Value (total, risk pool experience based)*		1.2307	1.1282	1.1274	1.0582	0.9728	0.8229	0.8057	0.7647	0.8322	1.0280	0.8117	0.8049	1.0727	1.3981	1.2125	1.1115	1.1108	1.0425	0.9584	0.8172	0.8001	0.7593	0.8264	1.0128	0.8061	0.7993	1.0568	1.3775	1.2307	1.1282
6	Plan Type*		EPO	MC	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	MC	Indemnity	EPO	MC	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	MC	Indemnity	EPO	MC
7	Plan Name*		NY Gold OAEPO 1000 90%	NY Silver OAMC 2000 80/60	NY Silver OAEPO 2000 90%	NY Silver OAEPO 2000 60%	NY Silver OAEPO 3000 70%	NY Bronze OAEPO 3500 50%	NY Bronze OAEPO 4000 80%	NY Bronze OAEPO 5000 60%	NY Bronze OAEPO 2500 100% HSA PY	NY Silver OAEPO 2000 80% HSA PY	NY Bronze OAEPO 3500 60% HSA PY	NY Bronze OAEPO 5000 100% HSA PY	NY Silver OAMC 2000 80/60 HSA PY	NY Silver Indemnity 2500 80%	NY Gold OAEPO 1000 90% RE	NY Silver OAMC 2000 80/60 RE	NY Silver OAEPO 2000 90% RE	NY Silver OAEPO 2000 60% RE	NY Silver OAEPO 3000 70% RE	NY Bronze OAEPO 3500 50% RE	NY Bronze OAEPO 4000 80% RE	NY Bronze OAEPO 5000 60% RE	NY Bronze OAEPO 2500 100% HSA PY RE	NY Silver OAEPO 2000 80% HSA PY RE	NY Bronze OAEPO 3500 60% HSA PY RE	NY Bronze OAEPO 5000 100% HSA PY RE	NY Silver OAMC 2000 80/60 HSA PY RE	NY Silver Indemnity 2500 80% RE	NY Gold OAEPO 1000 90%
8	Plan ID*		17210NY0090000	17210NY0070000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0070000	17210NY0080000	17210NY0090000	17210NY0070000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0070000	17210NY0080000	17210NY0090000
9	Exchange Plan?*		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

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

	Experience Period Index Rate																														
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period	123,897,552																													
10B	Member-Months for Latest Experience Period	348,588																													
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	355.43																													
11	Average Pricing Actuarial Value reflected in experience period	0.784																													
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**	**453.32**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate																														
13	Impact of adjusting experience period data to EHB benefit level	1.0244																													
14	Market wide adjustment for changes in provider network **	1.000																													
15	Market wide adjustment for fee schedule changes **	1.000																													
16	Market wide adjustment for utilization management changes **	1.000																													
17	Impact on risk pool of changes in expected covered membership risk characteristics **	0.888																													
18	Post ACA; Ratio Individual risk pool to Small Group risk pool [Indiv. Only]	1.000																													
19	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000																													
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery.	1.000																													
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000																													
22	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000																													
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.233																													
24	Other 1 (Adjustment to Silver Plan level)	0.714																													
25	Other 2 (Tier ratio adjustment)	1.092																													
26	Other 3 (pediatric dental)	1.007																													
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**	**0.881**

* * Not Included in Claim Trend Adjustment

	Plan Level Adjustments																														
28	Pricing actuarial value (without induced demand factor) #	1.000	0.793	0.688	0.720	0.718	0.683	0.619	0.613	0.614	0.612	0.720	0.620	0.617	0.720	0.686	0.793	0.688	0.720	0.718	0.683	0.619	0.613	0.614	0.612	0.720	0.620	0.617	0.720	0.686	
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.241	1.311	1.253	1.180	1.139	1.063	1.052	0.997	1.087	1.142	1.047	1.043	1.192	1.254	1.223	1.292	1.234	1.162	1.123	1.056	1.045	0.990	1.080	1.125	1.040	1.036	1.174	1.236	
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.300	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.300	
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
33	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
34	Administrative costs (excluding Exchange user fees and profits)	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	1.190	
35	Profit/Contribution to surplus margins	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	1.020	
36	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
38	Impact of Adjustment for Stop Loss reimbursements on S.G.HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
39	Other 1 (adjust Silver metal level 0.8 to Pricing Anchor 1.0)	1.000	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	1.250	
40	Other 2 (specify)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.214**	**1.494**	**1.369**	**1.368**	**1.284**	**1.181**	**0.999**	**0.978**	**0.928**	**1.010**	**1.248**	**0.985**	**0.977**	**1.302**	**1.697**	**1.472**	**1.349**	**1.348**	**1.265**	**1.163**	**0.992**	**0.971**	**0.922**	**1.003**	**1.229**	**0.978**	**0.970**	**1.283**	**1.672**	

\# C hanges that affect an entire standard population as cost sharing

c hanges, not based on health status, age, gender or occupation

\## B eyond what is reflected in Market Wide adjustments

42	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)**	**484.86**	**596.70**	**547.02**	**546.64**	**513.07**	**471.68**	**399.00**	**390.68**	**370.76**	**403.51**	**498.44**	**393.58**	**390.27**	**520.10**	**677.90**	**587.88**	**538.94**	**538.57**	**505.49**	**464.71**	**396.22**	**387.96**	**368.18**	**400.70**	**491.08**	**390.84**	**387.55**	**512.41**	**667.89**

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: 60054
SERFF Number: AETN-128993202
Market Segment: SG

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

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

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

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

projected prem
503.09

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	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as $pmpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as $pmpm	12.3 Commissions and broker fees - as $pmpm	12.4 Premium Taxes - as $pmpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as $pmpm	12.6 Other administrative expenses - as $pmpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as $pmpm	14. State income tax component - as $pmpm	15. Federal income tax component - as $pmpm	16. Reduction for assumed net investment income - as $pmpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Gold	Off Exchange	EPO	01/01/14	12/31/14	11.80%	0.11%	0.51%	6.09%	1.60%	3.63%	3.22%	15.16%	1.30%	0.00%	0.225%	0.70%	35.00%	-1.26%	15.91%	0.56	2.55	30.64	8.06	18.28	16.19	76.28	6.54	0.02	1.13	3.52	87.50
Silver	Off Exchange	EPO	01/01/14	12/31/14	11.80%	0.11%	0.51%	6.09%	1.60%	3.63%	3.22%	15.16%	1.30%	0.00%	0.23%	0.70%	35.00%	-1.26%	15.91%	0.56	2.55	30.64	8.06	18.28	16.19	76.28	6.54	0.02	1.13	3.52	87.50
Bronze	Off Exchange	EPO	01/01/14	12/31/14	11.80%	0.11%	0.51%	6.09%	1.60%	3.63%	3.22%	15.16%	1.30%	0.00%	0.23%	0.70%	35.00%	-1.26%	15.91%	0.56	2.55	30.64	8.06	18.28	16.19	76.28	6.54	0.02	1.13	3.52	87.50
Silver	Off Exchange	MC	01/01/14	12/31/14	11.80%	0.11%	0.51%	6.09%	1.60%	3.63%	3.22%	15.16%	1.30%	0.00%	0.23%	0.70%	35.00%	-1.26%	15.91%	0.56	2.55	30.64	8.06	18.28	16.19	76.28	6.54	0.02	1.13	3.52	87.50
Silver	Off Exchange	Indemnity	01/01/14	12/31/14	11.80%	0.11%	0.51%	6.09%	1.60%	3.63%	3.22%	15.16%	1.30%	0.00%	0.23%	0.70%	35.00%	-1.26%	15.91%	0.56	2.55	30.64	8.06	18.28	16.19	76.28	6.54	0.02	1.13	3.52	87.50
												0.00%							0.00%							0.00					0.00
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												0.00%							0.00%							0.00					0.00
												0.00%							0.00%							0.00					0.00
												0.00%							0.00%							0.00					0.00
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												0.00%							0.00%							0.00					0.00
												0.00%							0.00%							0.00					0.00
												0.00%							0.00%							0.00					0.00

Aetna Life Insurance Company
New York Small Group
Preferred Provider Organization

Summary

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

Who is affected?

The new rates will apply to policies that start from January 2014 through December 2014. Approximately 25,878 members currently are enrolled in plans that will no longer be available due to ACA provisions. These members will have the option to enroll in the new plans included in this filing.

What are the major factors driving the rate level?

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

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

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

How will premiums change?

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

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

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

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

What is Aetna doing to keep premiums affordable?

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

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

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

Data Collection Template

Company Legal Name: **Aetna Life Insurance Company** State: **NY**
HIOS Issuer ID: **17210** Market: **Small Group**
Effective Date of Rate Change(s): **01/01/2014**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

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

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	139,529,468	$449.32	100.00%
Incurred Claims in Experience Period	115,362,989	371.49	82.68%
Allowed Claims:	$152,522,840	491.16	109.31%
Index Rate of Experience Period		$491.00	
Experience Period Member Months	310,538		

Section II: Allowed Claims, PMPM basis

Projection Period: 01/01/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Days	285.43	4,398.28	$104.62	0.888	1.032	1.042	1.073	291.96	$4,926.38	$119.86	0.00	0.00	$0.00
Outpatient Hospital	Visits	414.56	1,501.73	51.88	0.888	1.032	1.042	1.073	424.05	1,682.04	59.44	0.00	0.00	0.00
Professional	Visits	7,306.04	200.26	121.92	0.888	1.032	1.042	1.073	7,473.17	224.30	139.69	0.00	0.00	0.00
Other Medical	Visits	5,714.87	220.42	104.97	0.888	1.032	1.042	1.073	5,845.60	246.89	120.27	0.00	0.00	0.00
Capitation	Benefit Period	0.00	0.00	0.00	0.888	1.032	1.042	1.073	0.00	0.00	0.00	0.00	0.00	0.00
Prescription Drug	Prescriptions	10,111.75	127.89	107.76	0.888	1.032	1.042	1.073	10,343.07	143.24	123.46	0.00	0.00	0.00
Total				$491.16							$562.71			$0.00

Section III: Projected Experience:

		After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	100.00%	$562.71	$182,252,053
Paid to Allowed Average Factor in Projection Period		0.710	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM		$399.53	$129,398,958
Projected Risk Adjustments PMPM		0.00	0
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM		$399.53	$129,398,958
Projected ACA reinsurance recoveries, net of rein prem, PMPM			
Projected Incurred Claims		$399.53	$129,398,958
Administrative Expense Load	10.30%	49.94	16,174,870
Profit & Risk Load	2.00%	9.70	3,140,751
Taxes & Fees	5.30%	25.70	8,322,991
Single Risk Pool Gross Premium Avg. Rate, PMPM		$484.86	$157,037,570
Index Rate for Projection Period		$561.80	
% increase over Experience Period		7.91%	
% Increase, annualized:		3.88%	
Projected Member Months			323,880

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

Product-Plan Data Collection

Company Legal Name:	**Aetna Life Insurance Company**	State:	**NY**
HIOS Issuer ID:	**17210**	Market:	**Small Group**
Effective Date of Rate Change(s):	**01/01/2014**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		Terminated Product	Terminated Product	Terminated Product																		
Product ID:		17210NY001	17210NY002	17210NY003																		
Metal:		Catastrophic	Catastrophic	Catastrophic	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold	Silver	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Silver
AV Metal Value		0.000	0.000	0.000	0.619	0.613	0.614	0.612	0.620	0.617	0.683	0.719	0.719	0.793	0.720	0.619	0.613	0.614	0.612	0.620	0.617	0.683
AV Pricing Value		0.000	0.000	0.000	0.823	0.806	0.765	0.832	0.812	0.805	0.973	1.058	1.127	1.231	1.028	0.823	0.806	0.765	0.832	0.812	0.805	0.973
Plan Type:		PPO	Indemnity	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
Plan Name		Terminated Product	Terminated Product	Terminated Product	OA EPO Bronze 3500 50	OA EPO Bronze 4000 80	OA EPO Bronze 5000 60	OA EPO HSA Comp 2500 100 PY	OA EPO HSA Comp 3500 60 PY	OA EPO HSA Comp 5000 100 PY	OA EPO Silver 3000 70	OA EPO Silver 2000 60	OA EPO Silver 2000 90	OA EPO Gold 1000 90	OA EPO HSA Comp 2000 80 PY	OA EPO Bronze 3500 50 RE	OA EPO Bronze 4000 80 RE	OA EPO Bronze 5000 60 RE	OA EPO HSA Comp 2500 100 PY RE	OA EPO HSA Comp 3500 60 PY RE	OA EPO HSA Comp 5000 100 PY RE	OA EPO Silver 3000 70 RE
Plan ID (Standard Component ID):		17210NY0010000	17210NY0020000	17210NY0030000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000
Exchange Plan?		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2		0.00%	0.00%	0.00%																		
Historical Rate Increase - Calendar Year - 1		0.00%	0.00%	0.00%																		
Historical Rate Increase - Calendar Year 0		0.00%	0.00%	0.00%																		
Effective Date of Proposed Rates		01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014
Rate Change % (over prior filing)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		0.00%	0.00%	0.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)		0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %		#DIV/0!	#DIV/0!	#DIV/0!																		

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

Plan ID (Standard Component ID):	Total	17210NY0010000	17210NY0020000	17210NY0030000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$484.86	$449.32	$0.00	$0.00	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86
Projected Member Months	323,880	0	0	0	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	17210NY0010000	17210NY0020000	17210NY0030000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000
Average Rate PMPM	$449.32	$449.32	$0.00	$0.00																		
Member Months	310,538	310,538	0	0																		
Total Premium (TP)	$139,529,468	$139,529,468	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHB basis or full portion of TP, [see instructions]	0.00%																					
state mandated benefits portion of TP that are other than EHB	0.00%																					
Other benefits portion of TP	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	$152,522,840	$152,522,840	$0	$0																		
EHB basis or full portion of TAC, [see instructions]	99.97%	99.97%	99.97%	99.97%																		
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%																		
Other benefits portion of TAC	0.03%	0.03%	0.03%	0.03%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Allowed Claims which are not the issuer's obligation:	$37,159,851	$37,159,851	$0	$0																		
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0																					
Portion of above payable by HHS on behalf of insured person, as %	0.00%																					
Total Incurred claims, payable with issuer funds	$115,362,989	$115,362,989	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Amt of Rein	$0.00	$0.00	$0.00	$0.00																		
Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00																		

Incurred Claims PMPM	$371.49	$371.49	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Allowed Claims PMPM	$491.16	$491.16	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
EHB portion of Allowed Claims, PMPM	$491.00	$491.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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

Plan ID (Standard Component ID):	Total	17210NY0010000	17210NY0020000	17210NY0030000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000	17210NY0090000
Average Rate PMPM	$484.86	$449.32	$0.00	$0.00	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86	$484.86
Member Months	323,880	-	-	-	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268	3,268
Total Premium (TP)	$157,036,399	$0	$0	$0	$1,584,313	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302	$1,584,302
EHB basis or full portion of TP, [see instructions]	99.84%				99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%
state mandated benefits portion of TP that are other than EHB	0.00%				0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.16%	100.00%	100.00%	100.00%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%
Total Allowed Claims (TAC)	$181,480,616				$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913	$1,830,913
EHB basis or full portion of TAC, [see instructions]	99.84%				99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%	99.84%
state mandated benefits portion of TAC that are other than EHB	0.00%				0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.16%	100.00%	100.00%	100.00%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%	0.16%
Allowed Claims which are not the issuer's obligation	$52,629,378				$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965	$530,965
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	$128,851,237	$0	$0	$0	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948	$1,299,948
Net Amt of Rein	$0				$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Amt of Risk Adj	$0				$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

[redacted]
Product & Regulatory Approvals
Law and Regulatory Affairs
55 Lane Road
Fairfield, N.J. 07004
[redacted]
Fax Number: [redacted]

May 15, 2013

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

Subject: **Aetna Life Insurance Company, NAIC No. 001-60054**
Accident & Health Insurance
Small Group Off-Exchange Accident & Health Insurance
Forms: OffHIXSGEPOGR-96817, et al

Dear [redacted]

The forms identified above and listed on the Attachment A of this submission are being submitted for the Department's review and approval on a general use basis. The forms are in final format rather than being drafts or proofs.

We intend to use the subject forms in connection with the small group segment Off-Exchange plans that will become available in your state effective January 1, 2014. The Schedules of Benefits attached to the forms support the Platinum, Gold, Silver and Bronze metallic plans, and are identified as such.

The products being offered in these Off-Exchange plans are Open Access EPO and Open Access Managed Choice (PPO).

The information that is applicable to the network, for the plans involved in this submission, is the same as that included with our April 30 submission for the On-Exchange individual plans (Forms HIXGR-96801, et al; SERFF Tracking Number AETN-129003886).

Enclosed also is the required Certification of Readability. 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.

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

Sincerely,

[redacted]
Product and Regulatory Approvals

Enclosures

List of Small Group Off-Exchange Forms

Small Group EPO Plans

OffHIXSGEPOGR-96817
OffHIXSGEPOGR-96817-Contra Rider
OffHIXSGEPOGR-96817-Deps Age 29
OffHIXSGEPOGR-96823
OffHIXSGEPOGR-96823-Contra Rider
OffHIXSGEPOGR-96823-Deps Age 29
OffHIXSG(EPOBronze2500100%HSAPY)GR-96823-SB
OffHIXSG(EPOBronze350050%)GR-96817-SB
OffHIXSG(EPOBronze350060%HSAPY)GR-96823-SB
OffHIXSG(EPOBronze400080%)GR-96817-SB
OffHIXSG(EPOBronze500060%)GR-96817-SB
OffHIXSG(EPOBronze5000100%HSAPY)GR-96823-SB
OffHIXSG(EPOGold100090%)GR-96817-SB
OffHIXSG(EPOSilver200060%)GR-96817-SB
OffHIXSG(EPOSilver200080%HSAPY)GR-96823-SB
OffHIXSG(EPOSilver200090%)GR-96817-SB
OffHIXSG(EPOSilver300070%)GR-96817-SB

Small Group OAMC Plans

OffHIXSGOAMCGR-96819
OffHIXSGOAMCGR-96819 –Contra Rider
OffHIXSGOAMCGR-96819-Deps Age 29
OffHIXSGOAMCGR-96824
OffHIXSGOAMCGR-96824 –Contra Rider
OffHIXSGOAMCGR-96824-Deps Age 29
OffHIXSG(OAMCSilver80%/60%HSAPY)GR-96824-SB
OffHIXSG(OAMCSilver80%/60%)GR-96819-SB

Small Group Indemnity Plans

OffHIXSGINDEMGR-96820
OffHIXSGINDEMGR-96820-Contra Rider
OffHIXSGINDEMGR-96820-Deps Age 29
OffHIXSG(IndemSilver250080%)GR-96820-SB

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/15/2013		Form	Section XIV. Bronze OAEPO 2500 100% HSA PY SCHEDULE OF BENEFITS Bronze	05/20/2013	OffHIXSG(EPOBronze2500100%HSAPY)GR-96823-SB.pdf