

State: New York **Filing Company:** Empire Health Choice Assurance, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: NY SG Off-Exch 0513 - Art42
Project Name/Number: SG Off-Ex 0513 Art 42/SG Off-Ex 0513 Art 42

Filing at a Glance

Company: Empire Health Choice Assurance, Inc.
Product Name: NY SG Off-Exch 0513 - Art42
State: New York
TOI: H16G Group Health - Major Medical
Sub-TOI: H16G.003G Small Group Only - Other
Filing Type: Off Exchange NG Forms & Rates
Date Submitted: 05/15/2013
SERFF Tr Num: AWLP-129023432
SERFF Status: Assigned
State Tr Num: 2013050124
State Status:
Co Tr Num: NY SG OFF-EXCH 0513 ART42

Implementation 01/01/2014

Date Requested:

Author(s): [Redacted]

Reviewer(s): [Redacted]

Disposition Date:

Disposition Status:

Implementation Date:

State Filing Description:

State: New York **Filing Company:** Empire Health Choice Assurance, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
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General Information

Project Name: SG Off-Ex 0513 Art 42 Status of Filing in Domicile:
 Project Number: SG Off-Ex 0513 Art 42 Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small
 Group Market Type: Employer Overall Rate Impact:
 Filing Status Changed: 05/16/2013
 State Status Changed: Deemer Date:
 Created By: [REDACTED] Submitted By: [REDACTED]
 Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:
SG Off-Exchange Filing Art42

Company and Contact

Filing Contact Information

[REDACTED] Commercial NY [REDACTED]
 One Liberty Plaza [REDACTED] [Phone]
 New York, NY 10006

Filing Company Information

Empire Health Choice Assurance, Inc.	CoCode: 55093	State of Domicile: New York
1 Liberty Plaza	Group Code: 671	Company Type: Life,
165 Broadway	Group Name: WellPoint Inc Group	Accident, Health
New York, NY 10006	FEIN Number: 23-7391136	State ID Number:
[REDACTED] ext. [Phone]		

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State Specific

State: New York **Filing Company:** Empire Health Choice Assurance, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
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1. Is a parallel product being submitted for another entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): Yes - For Empire HealthChoice HMO, Inc.; SERFF # AWLP-129002174
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Commercial
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): No
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Form and Rate
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation.): No
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): No

SERFF Tracking #:

AWLP-129023432

State Tracking #:

2013050124

Company Tracking #:

NY SG OFF-EXCH 0513 ART42

State:

New York

Filing Company:

Empire Health Choice Assurance, Inc.

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name:

NY SG Off-Exch 0513 - Art42

Project Name/Number:

SG Off-Ex 0513 Art 42/SG Off-Ex 0513 Art 42

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Empire Health Choice Assurance, Inc.	New Product	%	%				%	%

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

SERFF Tracking #:

AWLP-129023432

State Tracking #:

2013050124

Company Tracking #:

NY SG OFF-EXCH 0513 ART42

State: New York

Filing Company:

Empire Health Choice Assurance, Inc.

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Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		SG Off-exch rates 42		New		Total Manual Pages - 42r.pdf,

Empire HealthChoice Assurance, Inc
Community Rate Manual
(Open for New Sales)
Table of Contents

I. Direct Payment Products Open for Enrollment

a. Direct Pay Coverage Other Than Medicare Related Coverage

TraditionPlus Hospital (pre-2014)	1
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b. Direct Payment Medicare Supplemental Coverage

TraditionPlus Medicare Supplemental Program, Plan A	3
Medicare Supplemental Standard Plans (modernized)	3a
TraditionPlus Medicare Supplemental Program, Plan B	4
TraditionPlus Medicare Supplemental Program, Plan H including Drugs	5
TraditionPlus Medicare Supplemental Program, Plan C	5a
TraditionPlus Medicare Supplemental Program, Plan E	5b
TraditionPlus Medicare Supplemental Program, Plan F	5c
TraditionPlus Medicare Supplemental Program, Plan H excluding Drugs.....	5d
TraditionPlus Medicare Supplemental Program, Plan K	5e
TraditionPlus Medicare Supplemental Program, Plan L.....	5f

II. Small Group Products Open for Enrollment

PPO (pre-2014)	1
Essential EPO (pre-2014).....	10
2014 PPACA Compliant EPO Coverage	17
CDHP (pre-2014).....	103

III. Ancillary Coverages

Small Group Dental Product	1
Dental Rider	2

Appendix

Underwriting Guideline Summaries	
Commission Schedule	
Broker Administrative Service Reward Program	

Index

Rate Manual - Description of Benefits

Empire HealthChoice Assurance, Inc. Small Group

Form Numbers: NY_EPO_GA_012014

Index	HIOS Plan Name	INN Deductible	INN Coins.	INN OOP Max	OON Coverage
1	Empire Core Guided Access Plus w HSA gugb	\$3,500	20%	\$6,350	No
2	Empire Core Guided Access Plus w HSA gwgb	\$4,500	30%	\$6,350	No
3	Empire Essential Guided Access Plus gwoa	\$1,500	35%	\$6,350	No
4	Empire Essential Guided Access Plus w/Dental gwoa	\$1,500	35%	\$6,350	No
5	Empire Essential Guided Access Plus w HSA gbcb	\$2,500	20%	\$4,500	No

Rate Manual

Empire HealthChoice Assurance, Inc. Small Group

Quarter 1: January - March 2014

Form Numbers: NY_EPO_GA_012014

Albany (Region 1)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$396.48	\$792.96	\$674.02	\$1,129.97
2	Empire Core Guided Access Plus w HSA gwgb	\$373.64	\$747.28	\$635.19	\$1,064.87
3	Empire Essential Guided Access Plus gwoa	\$464.51	\$929.02	\$789.67	\$1,323.85
4	Empire Essential Guided Access Plus w/Dental gwoa	\$485.62	\$971.24	\$825.55	\$1,384.02
5	Empire Essential Guided Access Plus w HSA gbcb	\$458.47	\$916.94	\$779.40	\$1,306.64

Long Island (Region 8)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$392.28	\$784.56	\$666.88	\$1,118.00
2	Empire Core Guided Access Plus w HSA gwgb	\$369.68	\$739.36	\$628.46	\$1,053.59
3	Empire Essential Guided Access Plus gwoa	\$459.59	\$919.18	\$781.30	\$1,309.83
4	Empire Essential Guided Access Plus w/Dental gwoa	\$480.47	\$960.94	\$816.80	\$1,369.34
5	Empire Essential Guided Access Plus w HSA gbcb	\$453.61	\$907.22	\$771.14	\$1,292.79

Mid-Hudson (Region 3)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$464.39	\$928.78	\$789.46	\$1,323.51
2	Empire Core Guided Access Plus w HSA gwgb	\$437.63	\$875.26	\$743.97	\$1,247.25
3	Empire Essential Guided Access Plus gwoa	\$544.07	\$1,088.14	\$924.92	\$1,550.60
4	Empire Essential Guided Access Plus w/Dental gwoa	\$568.79	\$1,137.58	\$966.94	\$1,621.05
5	Empire Essential Guided Access Plus w HSA gbcb	\$536.99	\$1,073.98	\$912.88	\$1,530.42

New York City (Region 4)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$434.18	\$868.36	\$738.11	\$1,237.41
2	Empire Core Guided Access Plus w HSA gwgb	\$409.16	\$818.32	\$695.57	\$1,166.11
3	Empire Essential Guided Access Plus gwoa	\$508.67	\$1,017.34	\$864.74	\$1,449.71
4	Empire Essential Guided Access Plus w/Dental gwoa	\$531.79	\$1,063.58	\$904.04	\$1,515.60
5	Empire Essential Guided Access Plus w HSA gbcb	\$502.05	\$1,004.10	\$853.49	\$1,430.84

Upstate (Region 7)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$590.13	\$1,180.26	\$1,003.22	\$1,681.87
2	Empire Core Guided Access Plus w HSA gwgb	\$556.12	\$1,112.24	\$945.40	\$1,584.94
3	Empire Essential Guided Access Plus gwoa	\$691.38	\$1,382.76	\$1,175.35	\$1,970.43
4	Empire Essential Guided Access Plus w/Dental gwoa	\$722.79	\$1,445.58	\$1,228.74	\$2,059.95
5	Empire Essential Guided Access Plus w HSA gbcb	\$682.38	\$1,364.76	\$1,160.05	\$1,944.78

Rate Manual

Empire HealthChoice Assurance, Inc. Small Group

Quarter 2: April - June 2014

Form Numbers: NY_EPO_GA_012014

Albany (Region 1)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$407.59	\$815.18	\$692.90	\$1,161.63
2	Empire Core Guided Access Plus w HSA gwgb	\$384.10	\$768.20	\$652.97	\$1,094.69
3	Empire Essential Guided Access Plus gwoa	\$477.52	\$955.04	\$811.78	\$1,360.93
4	Empire Essential Guided Access Plus w/Dental gwoa	\$499.21	\$998.42	\$848.66	\$1,422.75
5	Empire Essential Guided Access Plus w HSA gbcb	\$471.30	\$942.60	\$801.21	\$1,343.21

Long Island (Region 8)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$403.27	\$806.54	\$685.56	\$1,149.32
2	Empire Core Guided Access Plus w HSA gwgb	\$380.03	\$760.06	\$646.05	\$1,083.09
3	Empire Essential Guided Access Plus gwoa	\$472.46	\$944.92	\$803.18	\$1,346.51
4	Empire Essential Guided Access Plus w/Dental gwoa	\$493.92	\$987.84	\$839.66	\$1,407.67
5	Empire Essential Guided Access Plus w HSA gbcb	\$466.31	\$932.62	\$792.73	\$1,328.98

Mid-Hudson (Region 3)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$477.40	\$954.80	\$811.58	\$1,360.59
2	Empire Core Guided Access Plus w HSA gwgb	\$449.89	\$899.78	\$764.81	\$1,282.19
3	Empire Essential Guided Access Plus gwoa	\$559.31	\$1,118.62	\$950.83	\$1,594.03
4	Empire Essential Guided Access Plus w/Dental gwoa	\$584.72	\$1,169.44	\$994.02	\$1,666.45
5	Empire Essential Guided Access Plus w HSA gbcb	\$552.03	\$1,104.06	\$938.45	\$1,573.29

New York City (Region 4)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$446.34	\$892.68	\$758.78	\$1,272.07
2	Empire Core Guided Access Plus w HSA gwgb	\$420.62	\$841.24	\$715.05	\$1,198.77
3	Empire Essential Guided Access Plus gwoa	\$522.92	\$1,045.84	\$888.96	\$1,490.32
4	Empire Essential Guided Access Plus w/Dental gwoa	\$546.68	\$1,093.36	\$929.36	\$1,558.04
5	Empire Essential Guided Access Plus w HSA gbcb	\$516.11	\$1,032.22	\$877.39	\$1,470.91

Upstate (Region 7)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$606.65	\$1,213.30	\$1,031.31	\$1,728.95
2	Empire Core Guided Access Plus w HSA gwgb	\$571.69	\$1,143.38	\$971.87	\$1,629.32
3	Empire Essential Guided Access Plus gwoa	\$710.74	\$1,421.48	\$1,208.26	\$2,025.61
4	Empire Essential Guided Access Plus w/Dental gwoa	\$743.03	\$1,486.06	\$1,263.15	\$2,117.64
5	Empire Essential Guided Access Plus w HSA gbcb	\$701.49	\$1,402.98	\$1,192.53	\$1,999.25

Rate Manual

Empire HealthChoice Assurance, Inc. Small Group

Quarter 3: July - September 2014

Form Numbers: NY_EPO_GA_012014

Albany (Region 1)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$419.01	\$838.02	\$712.32	\$1,194.18
2	Empire Core Guided Access Plus w HSA gwgb	\$394.86	\$789.72	\$671.26	\$1,125.35
3	Empire Essential Guided Access Plus gwoa	\$490.90	\$981.80	\$834.53	\$1,399.07
4	Empire Essential Guided Access Plus w/Dental gwoa	\$513.20	\$1,026.40	\$872.44	\$1,462.62
5	Empire Essential Guided Access Plus w HSA gbcb	\$484.51	\$969.02	\$823.67	\$1,380.85

Long Island (Region 8)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$414.56	\$829.12	\$704.75	\$1,181.50
2	Empire Core Guided Access Plus w HSA gwgb	\$390.68	\$781.36	\$664.16	\$1,113.44
3	Empire Essential Guided Access Plus gwoa	\$485.69	\$971.38	\$825.67	\$1,384.22
4	Empire Essential Guided Access Plus w/Dental gwoa	\$507.76	\$1,015.52	\$863.19	\$1,447.12
5	Empire Essential Guided Access Plus w HSA gbcb	\$479.37	\$958.74	\$814.93	\$1,366.20

Mid-Hudson (Region 3)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$490.77	\$981.54	\$834.31	\$1,398.69
2	Empire Core Guided Access Plus w HSA gwgb	\$462.49	\$924.98	\$786.23	\$1,318.10
3	Empire Essential Guided Access Plus gwoa	\$574.98	\$1,149.96	\$977.47	\$1,638.69
4	Empire Essential Guided Access Plus w/Dental gwoa	\$601.10	\$1,202.20	\$1,021.87	\$1,713.14
5	Empire Essential Guided Access Plus w HSA gbcb	\$567.49	\$1,134.98	\$964.73	\$1,617.35

New York City (Region 4)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$458.84	\$917.68	\$780.03	\$1,307.69
2	Empire Core Guided Access Plus w HSA gwgb	\$432.40	\$864.80	\$735.08	\$1,232.34
3	Empire Essential Guided Access Plus gwoa	\$537.57	\$1,075.14	\$913.87	\$1,532.07
4	Empire Essential Guided Access Plus w/Dental gwoa	\$561.99	\$1,123.98	\$955.38	\$1,601.67
5	Empire Essential Guided Access Plus w HSA gbcb	\$530.57	\$1,061.14	\$901.97	\$1,512.12

Upstate (Region 7)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$623.65	\$1,247.30	\$1,060.21	\$1,777.40
2	Empire Core Guided Access Plus w HSA gwgb	\$587.71	\$1,175.42	\$999.11	\$1,674.97
3	Empire Essential Guided Access Plus gwoa	\$730.65	\$1,461.30	\$1,242.11	\$2,082.35
4	Empire Essential Guided Access Plus w/Dental gwoa	\$763.84	\$1,527.68	\$1,298.53	\$2,176.94
5	Empire Essential Guided Access Plus w HSA gbcb	\$721.14	\$1,442.28	\$1,225.94	\$2,055.25

Rate Manual

Empire HealthChoice Assurance, Inc. Small Group

Quarter 4: October - December 2014

Form Numbers: NY_EPO_GA_012014

Albany (Region 1)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$430.74	\$861.48	\$732.26	\$1,227.61
2	Empire Core Guided Access Plus w HSA gwgb	\$405.92	\$811.84	\$690.06	\$1,156.87
3	Empire Essential Guided Access Plus gwoa	\$504.65	\$1,009.30	\$857.91	\$1,438.25
4	Empire Essential Guided Access Plus w/Dental gwoa	\$527.57	\$1,055.14	\$896.87	\$1,503.57
5	Empire Essential Guided Access Plus w HSA gbcb	\$498.08	\$996.16	\$846.74	\$1,419.53

Long Island (Region 8)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$426.18	\$852.36	\$724.51	\$1,214.61
2	Empire Core Guided Access Plus w HSA gwgb	\$401.62	\$803.24	\$682.75	\$1,144.62
3	Empire Essential Guided Access Plus gwoa	\$499.30	\$998.60	\$848.81	\$1,423.01
4	Empire Essential Guided Access Plus w/Dental gwoa	\$521.98	\$1,043.96	\$887.37	\$1,487.64
5	Empire Essential Guided Access Plus w HSA gbcb	\$492.80	\$985.60	\$837.76	\$1,404.48

Mid-Hudson (Region 3)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$504.52	\$1,009.04	\$857.68	\$1,437.88
2	Empire Core Guided Access Plus w HSA gwgb	\$475.45	\$950.90	\$808.27	\$1,355.03
3	Empire Essential Guided Access Plus gwoa	\$591.08	\$1,182.16	\$1,004.84	\$1,684.58
4	Empire Essential Guided Access Plus w/Dental gwoa	\$617.94	\$1,235.88	\$1,050.50	\$1,761.13
5	Empire Essential Guided Access Plus w HSA gbcb	\$583.39	\$1,166.78	\$991.76	\$1,662.66

New York City (Region 4)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$471.69	\$943.38	\$801.87	\$1,344.32
2	Empire Core Guided Access Plus w HSA gwgb	\$444.51	\$889.02	\$755.67	\$1,266.85
3	Empire Essential Guided Access Plus gwoa	\$552.62	\$1,105.24	\$939.45	\$1,574.97
4	Empire Essential Guided Access Plus w/Dental gwoa	\$577.73	\$1,155.46	\$982.14	\$1,646.53
5	Empire Essential Guided Access Plus w HSA gbcb	\$545.43	\$1,090.86	\$927.23	\$1,554.48

Upstate (Region 7)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Core Guided Access Plus w HSA gugb	\$641.11	\$1,282.22	\$1,089.89	\$1,827.16
2	Empire Core Guided Access Plus w HSA gwgb	\$604.17	\$1,208.34	\$1,027.09	\$1,721.88
3	Empire Essential Guided Access Plus gwoa	\$751.11	\$1,502.22	\$1,276.89	\$2,140.66
4	Empire Essential Guided Access Plus w/Dental gwoa	\$785.24	\$1,570.48	\$1,334.91	\$2,237.93
5	Empire Essential Guided Access Plus w HSA gbcb	\$741.34	\$1,482.68	\$1,260.28	\$2,112.82

Empire HealthChoice Assurance, Inc Small Group OFF-Exchange Plans

gated in-network coverage only using the pathway network

Plan Name	Deductible Single/ Family	Office Visit			Coinsurance	Annual OOP Max Single/ Family	Pharmacy	Inpatient Hospital	Emergency Room (Facility)	Urgent Care	Outpt Hospital (Facility)	Maternity & Newborn Care	Mental Health & Substance Abuse	Rehab & Habilitative
		PCP	Specialist	Online Visits										
BRONZE														
Empire Core Guided Access Plus EPO with H.S.A. (gwgb)	\$4500/\$9000	\$50	\$75	\$50	30%	\$6,350/ \$12,700	\$15/\$60/30%	ded/coins	ded/coins	Ded then copay \$75	ded/coins	ded/coins	ded/coins	ded/coins
Empire Core Guided Access Plus EPO with H.S.A. (gugb)	\$3500/\$7000	\$30	\$60	\$30	20%	\$6,350/ \$12,700	\$15/\$50/25%	ded/coins	ded/coins	Ded then copay \$60	ded/coins	ded/coins	ded/coins	ded/coins
SILVER														
Empire Essential Guided Access Plus EPO (gwoa)	\$1500/\$3000	\$35 (first 3 combined OVs), then ded & coins of 35%	\$35 (first 3 combined OVs), then ded & coins of 35%	\$35 (first 3 combined OVs), then ded & coins of 35%	35%	\$6,350/ \$12,700	\$15/35/30%	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins
Empire Essential Guided Access Plus EPO (gwoa) [with adult dental]	\$1500/\$3000	\$35 (first 3 visits), then 35%	\$35 (first 3 visits), then 35%	\$35 (first 3 combined OVs), then ded & coins of 35%	35%	\$6,350/ \$12,700	\$15/35/30%	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins
Empire Essential Guided Access Plus EPO with H.S.A. (gbcb)	\$2500/\$5000	ded/coins	ded/coins	ded/coins	20%	\$4,500/ \$9,000	Ded/20%	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins

Rate Manual

Empire HealthChoice Assurance Inc. Small Group

Effective Date: January 1, 2014

Description	Form Number	Single	Couple	Parent/ Child(ren)	Family
Domestic Partner Coverage	[Variable option to base]	0%	0%	0%	0%
Dependent Coverage through Age 29	RIDER-Age 29-42	0%	0%	4.0%	4.0%
Unlimited Days of SNF Coverage	[Variable option to base]	0.07%	0.07%	0.07%	0.07%
Opt-out of Contraceptive Coverage	[Variable option to base]	-0.7%	-0.7%	-0.7%	-0.7%
Member Opt-in of Contraceptive Coverage	RIDER-WPS-42	\$3.20	\$6.40	\$5.44	\$9.12

SUMMARY OF NEW YORK SMALL GROUP UNDERWRITING GUIDELINES

Empire Blue Cross and Blue Shield Community Rated Small Group policies are for businesses with at least 2 eligible employees, and no more than 50 eligible employees. The Small Group premium bills are sent to the group business address. The rates Small Groups pay are determined by the combined experience of all members of the Small Group pool, derived from all such groups without regard to age, sex, health status or occupation.

The underwriting guidelines for Small Groups conform to all appropriate laws and regulations.

Major underwriting guidelines applicable to Small Group coverages eligibility are:

- A small group must have at least 2 eligible, active, full-time employees (working at least 20 hours per week), but no more than 50 eligible employees. Age, sex, health status or occupation cannot be considered in determining eligibility.
- A small group must have a bona fide New York business address in Empire's New York operating area.
- A small group with at least 2 eligible, active, full-time employees may enroll owners, partners, officers, paid board members, COBRA employees and retirees. We request that the employer contribute at least 50% toward retiree premium.
- Temporary employees, consultants and independent contractors are ineligible.
- In general, minimum participation rules require the greater of 2 enrolled or 60% participation for non-HMO coverage with no waivers of additional non-enrolled members. HMO coverage has no minimum participation requirement. HMO enrollment is recognized in the minimum participation calculation under an indemnity plan.
- A copy of the officially submitted NYS-45-ATT to the State and a complete and current payroll listing is required to verify group legitimacy and active employees. When the NYS-45 or payroll listing is not available, for certain classes of other eligible individuals and to verify exclusion status, other supporting documentation is required.
- An Empire small group may enroll a new member via the employer e-business website with on-line certification of employee eligibility and enrollment. Upon Empire's review, subsequent paper submission of proof of employment may be requested from the employer to validate on-line member enrollment.
- Segmentation is not allowed.
- Dependents, including legal spouses, are eligible for coverage under family policies subject to the eligibility terms and criteria specified in the policy. Special rules apply for adoptive newborns and domestic partners. Foster children and grandchildren are not eligible.
- Groups composed entirely of retirees or entirely of COBRA employees are ineligible.

The major underwriting guidelines applicable to New York Small Group coverage termination are:

- Coverage will be terminated for failure to pay premiums by the end of the grace period; coverage will be terminated as of the paid-to-date.
- Coverage may be terminated if a group fails to meet minimum participation requirements, where permitted. This will be assessed periodically in connection with the group's renewal date.
- Coverage will be terminated if a group exceeds the maximum enrollment requirement of 50 for a Small Group at its renewal date. However if the group meets all applicable underwriting guidelines, it may be able to transfer to a large group basis. Otherwise, coverage will be terminated.
- Coverage will be terminated if a group falls below the minimum eligibility requirement of 2 for Small Group. Conversion privileges to direct payment may apply.
- Coverage may be terminated at the group's request in writing to Empire as outlined in the specific benefit contract.
- Coverage will be terminated if the organization ceases to exist.
- Coverage will be terminated if the group transfers to another carrier.
- Coverage will be terminated when Empire determines/identifies the group no longer meets underwriting requirements as set forth in the Small Group Underwriting Manual.
- Coverage will be terminated if the group fails to respond to requests for re-credentialing information.

SUMMARY OF DIRECT PAY UNDERWRITING GUIDELINES

Empire HealthChoice Assurance, Inc. Direct Pay policies are for individuals or families who have no group affiliation from which they could receive health insurance coverage. Direct Pay premium bills are usually sent to the subscriber's home. The rates Direct Pay subscribers pay are determined by the experience of the Direct Pay pool of all members.

The underwriting guidelines for Direct Pay policies conform to all appropriate insurance laws and regulations.

Major underwriting guidelines applicable to Direct Pay coverage eligibility are:

- Direct Pay, non-Medicare Related. Coverage is intended for persons, of majority age but less than 65, who are not eligible for Medicare, nor enrolled for comparable group coverage through an employer.
- Direct Pay, Medicare Related. Coverage is intended for persons over age 65, or under 65 and disabled, enrolled in both Medicare Parts A and B, are eligible for Medicare Related coverage.

Eligibility

- An applicant, with proof of residency, must be a resident of Empire's operating area in New York.
- The applicant and/or disabled dependent must have a valid Social Security number, to determine Medicare eligibility or enrollment.
- A dependent is eligible for coverage under a family policy if he/she is a legal spouse, an unmarried dependent child, a legally adopted or natural born child or stepchild, adopted dependent child, unmarried disabled/mentally retarded child or legal ward. Special rules apply for adoptive newborns. Foster children are not eligible.

Ineligibility

- Any individual who is enrolled under another group or Direct Pay plan, which would duplicate any benefits covered under Empire's policy, is ineligible for Direct Pay coverage.
- Any individual whose health insurance coverage, with Empire or another carrier, had been terminated within the previous 12 months for nonpayment of premium, is not eligible for coverage for 12 months after the date of contract termination.

The major underwriting guidelines applicable to Direct Pay coverage termination are:

- Coverage will be terminated for failure to pay premiums by the end of the grace period; coverage will be terminated as described in the contract.
- Coverage will continue when a subscriber or dependent becomes eligible for Medicare but will be subject to applicable rules regarding primacy of coverage, e.g., "who pays first".
- Subscribers may request termination in writing at any time.
- Coverage will be terminated in accordance with overinsurance rules approved by the New York State Insurance Department.
- Reinstatement of terminated coverage is at the option of Empire.
- When a subscriber dies, all coverage terminates on the day following death. Surviving dependents may purchase a new contract as direct payment members. Coverage will be terminated when Empire determines/identifies the subscriber no longer meets the underwriting requirements.

**Empire HealthChoice Assurance, Inc
Rate Manual
Index**

<u>Form Number</u>	<u>Page</u>
A DP-HOSP	I-1
A-KW-DENT-HO-PLUS	III-1
EHCA, Inc. (Small-Make Available)	II-3a, II-14, II-108
EHAMSA	I-3
EHAMSB	I-4
EHAMSC-IND	I-5a
EHAMSE-IND	I-5b
EHAMSF-IND	I-5c
EHAMSH-IND	I-5
EHAMSH-IND-05	I-5d
EHAMSK-IND-06	I-5e
EHAMSL-IND-06	I-5f
NY_EPO_GA_012014	II-17
PPO/POS-95: I/N I/P REHAB-Rev. 6/98	II-3a, II-14
R-42 VISION	II-3a, II-14, II-108
R-42 VISION EXAM	II-14, II-108
R-Age 29-Make Available Option-42.Rev	II-14, II-108
R-ContraRx&Dev42	II-2-1 thru II-2-4, II-4 thru II-4.11, II-10-9 thru II-10-12, II-11 thru II-11-11, II-107
R-ContraRxGen 42	II-2-1 thru II-2-4, II-10-9 thru II-10-12
R-FIT-CTR-42 2011	II-3b, II-108
R-FMHP-MH/SA-42 2009	II-3b, II-14, II-108
R-H-Inp.Rehab-42	II-108
R-PPO-SG.Rev0111	II-1-1 thru II-1-4
RIDER-Age 29-42	II-23
RIDER-WPS-42	II-23
RX-NOC-42-DedCopay.Rev0411	II-107
RX-NOC-42.Rev1011	II-2-1 thru II-2-4, II-10-9 thru II-10-12
RX-NOC-42-GEN10.Rev1011	II-2-1 thru II-2-4, II-10-9 thru II-10-12
RX-R-Tier-42	II-107
RX-SOB-3T-42-SG	II-2-1 thru II-2-4, II-10-9 thru II-10-12
RX-SOB-3T-HSA-SG.Rev0110	II-107
R SG DomPart 42	II-3a, II-14
Sched.PPO42-HAS Small	II-103 thru II-106, II-108
SOB-EPO-Blue Essential 2011	II-14
WPLANBM(09)-NY	I-3a
WPLANFM(09)	I-3a
WPLANHiFM(09)	I-3a
WPLANGM(09)	I-3a
WPLANNM(09)	I-3a

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

Review Standards for

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

Instructions for SERFF Checklist:

- A. For **ALL** filings, the “General Requirements for All Filings” section must be completed:
- B. For a **FORM** filing, completion of additional sections may be required as follows, depending on the type of form being submitted:
- Policy or Contract – Also complete all sections
 - Rider or endorsement – Also complete all items relevant to the form being submitted in all sections.
- C. For filing of initial rates, complete the section entitled “Actuarial Section for New Product Rate Filings Only” in addition to completion of the applicable form sections identified above. For filing of rate changes to existing products (increases, decreases, or change in rate calculation rules or procedures), complete the “Actuarial Section for Existing Product Rate Filings Only” section. For filing of any other changes to rate or underwriting manuals (e.g., changes in commissions or underwriting), complete the “Actuarial Section for Existing Product Rate Filings Only” section.
- D. For each item, enter in the last column the form number(s), page number(s) and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing. All items with shaded boxes must be answered.
- E. Do not make any changes or revisions to this checklist.
- F. **Checklist Updates:** Any items on the checklist that have been updated since the last posting are shaded.
- G. **Instructions for Citations:** All citations to Insurance regulations link to the Department of State’s website and an unofficial copy of the NYCRR. Please select title 11 for Insurance regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, please select the link labeled “ISC”.

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		(If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: <ul style="list-style-type: none"> • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as “will conform to law” or “as requested by group” to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF. 	
Flesch Score	§3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF Filing Description or a letter of submission that contains the following: <ul style="list-style-type: none"> • The identifying form number of each form submitted. §52.33(a) • If the form is a policy or contract, the letter must indicate that the policy or contract is submitted pursuant to 11 NYCRR 52.7. §52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f) • If the form is other than a policy or contract form, the letter must identify the form number and 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<p>approval date of the policy or contract with which it will be used. If the form is for general use, the Department may accept a description of the type of policy or contract with which it may be used in lieu of the form number and approval date. §52.33(g)</p> <ul style="list-style-type: none"> • If the form is a policy or contract, the letter must identify the form numbers and dates of approval of any applications previously approved to be used with the policy or contract unless the application is required to be attached to the policy or contract upon submission. §52.33(h) • If the policy or contract is designed to be used with insert pages, the letter must contain a statement of the insert page forms which must always be included in the policy or contract and a list of all optional pages, together with an explanation of their use. § 52.33(i) • <i>Note: Submission letters and or the SERFF filing description should advise as to whether the policy or contract is intended for internet sales and should describe any proposed electronic procedures and/or the proposed use of electronic signatures associated with the sale of the policy or contract.</i> 	
<p>Group Status and Recognition</p>	<p>§ 4235(c)(1)(A) §3201(b)(1) 11 NYCRR 59</p>	<p>The SERFF filing description or submission letter should include a statement that policy or contract forms will be sold to a group specified in Insurance Law §4235(c)(1). However, a more detailed statement must be included where discretionary group status is sought under Insurance Law §4235(c)(1)(M). The size of the group should be indicated as small. Please indicate whether the submission is for general use or is submitted on a one case basis. If the submission is for use on a one case basis, the group must be identified along with the subpart of Insurance Law §4235(c)(1) in which the group fits and a confirmation that the group meets all of the requirements of the identified subpart.</p> <p>Requests for discretionary group recognition, pursuant to Insurance Law §4235(c)(1)(M), must be accompanied by written documentation that demonstrates that the proposed group meets each and every element stated in the named statute. The documentation must also make clear that the request for discretionary group recognition is not a subterfuge, evasion technique, or a marketing tool to avoid compliance with other statutory or regulatory requirements and recognized marketing mechanisms. This provision is not intended to allow approval of groups recognized in the various subparagraphs of §4235(c)(1), but for which the proposed discretionary group does not meet one or more of the requisites specifically required or proscribed by §4235. The request for allowance of a discretionary group must be granted before it may be used.</p> <p>Pursuant to §3201(b)(1) and Insurance Regulation 123, an accident and health certificate is deemed delivered in New York and subject to review and approval regardless of the actual place of delivery, if the policy is issued to certain groups. In these cases, the group certificate is reviewed for compliance with New York Law. The group policy/contract that is delivered out-of-state is not reviewed.</p>	
<p>Prefiled Group Coverage</p>	<p>11 NYCRR 52.32</p>	<p>A copy of the letter of confirmation sent to the group by the insurer must be submitted to the Department within 30 days after the date the insurer agrees to provide insurance and must include the following:</p> <ul style="list-style-type: none"> • The effective date of coverage. § 52.32(a)(1) • The nature and extent of the benefits or change in benefits as then known. § 52.32(a)(2) • That the contractual forms may be executed and issued for delivery only after filing with or 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<p>approval by the Department. §52.32(a)(3)</p> <ul style="list-style-type: none"> That if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval. §52.32(a)(4) <p><i>Note: At the time the insurer agrees to provide insurance, it cannot have been reasonably possible to obtain approval prior to the effective date of coverage because the group requested the insurer provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the insurer agrees to provide insurance. § 52.32(c). Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.</i></p>	
<p>Statement of ERISA rights</p> <p>Is the insurer providing document as the plan administrator or for the plan administrator? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)</p>	<p>Plan administrators of an employee benefit plan are required to furnish a copy of a Statement of ERISA rights as provided for in 29 CFR § 2520.102-3(t). If the insurer is providing this document as the plan administrator, or for the plan administrator, please indicate in the adjacent box.</p>	
<p>APPLICATION FORMS</p> <p>Model Application Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>		<p>Form/Page/Para Reference</p>
<p>Authorization</p>	<p>11 NYCRR 420.18(b)</p>	<p>If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.</p>	<p>application will be submitted via separate filing</p>
<p>Fraud Warning Statement</p>	<p>§403(d) 11 NYCRR 86.4</p>	<p>The application contains the prescribed fraud warning statement immediately above the insured's signature.</p>	
<p>Prohibited Questions and Provisions</p>	<p>§3221(q)(1) §3204 11 NYCRR 52.51</p>	<p>The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy or contract to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy or contract void. An agreement that acceptance of any policy or contract issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).</p>	
<p>Verification of Compliance with Pediatric Essential Dental Health Benefit.</p>	<p>45 CFR § 156.150</p>	<p>In order to verify whether an individual has obtained stand-alone dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange, insurers should use the following language on their application/enrollment form:</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<p>A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? Yes No</p> <p>B. If you answered “yes”, please provide the name of the company issuing the stand-alone dental coverage. _____ If you answered “no”, we will provide you coverage of the pediatric dental essential health benefit.</p>	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	page i
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	page i
Table of Contents Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 3217 Model Language	A table of contents is required.	page ii
DEFINITIONS Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§ 3217 Model Language	<i>For a complete listing of the definitions click on the adjacent Model Language link.</i>	Form/Page/Para Reference
Services Performed at Comprehensive Care Center for Eating Disorders	§3221(k)(14) §4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers’ network of practitioners and providers are required to provide.	
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	page 7
Designation of Primary Care	§3217-e	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract	page 7

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Provider (PCP) & Access to Pediatrics</p> <p>Does this product require a PCP to be designated? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language</p>	<p>form permits an insured to designate any participating PCP who is available to accept the insured.</p> <p>If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.</p>	
<p>Direct Access to OB/GYN Services</p> <p>Does this product require a PCP to be designated? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language</p>	<p>If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that:</p> <ul style="list-style-type: none"> • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer. 	<p>page 7</p>
Preauthorization			
<p>Preauthorization Requirements</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b) Model Language</p>	<p>This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or \$500.00, whichever is less, is permissible.</p>	<p>page 8</p>
Medical Necessity			
<p>Definition of Medical Necessity</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(1) §4324(a)(1) Model Language</p>	<p>This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.</p>	<p>page 8</p>
<p>Contact Information</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(16) §4324(a)(16) PHL §4408(1)(q) Model Language</p>	<p>This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.</p>	<p>page 10</p>
ACCESS TO CARE AND TRANSITIONAL CARE			
<p>Referral to Non-Participating Providers</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) Model Language</p>	<p>If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the</p>	<p>page 11</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		insured can obtain such referral.	
Specialty Care Provider as PCP Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	page 11
Standing Referrals Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	page 11
Specialty Care Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	page 11
Transitional Care When A Provider Leaves the Network Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4804(e) §3217-d(c) §4306-C(c) PHL §4403(6)(e) Model Language	<p>If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery.</p> <p>In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.</p>	page 12
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	<p>If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery.</p> <p>In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the</p>	page 12

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	page 14
Reimbursement of Providers Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	page 15
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	§3217-a(a)(6) §4324(a)(6) PHL §4408(1)(f) Model Language	This policy or contract form includes a description of the insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	not applicable, OON benefits are not covered, except for Emergency and Urgent Care
ELIGIBILITY Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language		Form/Page/Para Reference
Spouse	§4235(f)(1)(A) §4305(c)(1) Circular Letter No. 27 (2008) Model Language	If dependent coverage is selected by the group, this policy or contract form must provide coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex partners legally performed in this state and in other jurisdictions.	page 17
Dependents	§4235(f)(1)(A)(i) §4305(c)(1) §3221(a)(7) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	If dependent coverage is selected by the group, this policy or contract form provides coverage of children until age 26. <i>Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.</i>	page 17

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Extended Dependent Coverage</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§4235(f)(1)(B) §4305(c)(1)</p> <p>Model Language</p>	<p>If dependent coverage is selected by the group, this policy or contract must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer.</p> <p>The company must comply with the notice requirements set forth in 4235(f).</p>	<p>available via separate Rider: RIDER-Age 29-42</p>
<p>Unmarried Students on Medical Leave of Absence</p>	<p>§3237 §4306-a</p> <p>42 USC §300gg-7</p>	<p>If this policy or contract form provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness or injury for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.</p>	<p>n/a dependents covered only up to age 26</p>
<p>Unmarried Disabled Children</p>	<p>§4235(f)(1)(A)(ii) §4305(c)(1)</p> <p>Model Language</p>	<p>If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.</p> <p><i>Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i></p>	<p>page 17</p>
<p>Newborn Infants</p>	<p>§4235(f)(2) §4305(c)(1)</p> <p>Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725</p>	<p>If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care.</p> <p><i>Note: In the case of individual or two-person coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.</i></p>	<p>page 18</p>
<p>Adopted Children and Step-Children</p>	<p>11NYCRR52.18(e)(2); (3) §4305(c)(1)</p>	<p>If dependent coverage is selected by the policyholder or contractholder, this policy or contract form provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage</p>	<p>page 17</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners	§4235(f)(1)(A) §4305(c)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: <ul style="list-style-type: none"> • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	page 19; and included in spouse definition page 17
New Family Members Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 C.F.R. § 155.420 Model Language	The policy or contract form describes the requirements to add new family members to the policy or contract.	page 18
New Employees	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	
Enrollment Periods	http://government.westlaw.com/linkedslice/default.asp?SP=nycr 100011NYCRR52.70(e)(3) 45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	page 18
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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<p>limitations; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance, as well as DFS review.</p> <p>The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative</p>	
PREVENTIVE CARE			
<p>Primary and Preventive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(l)(8) §3221(k)(18) §4303(j) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100</p>	<p>This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19:</p> <ul style="list-style-type: none"> • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 21</p>
<p>Federal Mandated Preventive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing:</p> <ul style="list-style-type: none"> • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 21</p>
<p>Cervical Cytology Screening</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	<p>page 22</p>
<p>Mammography Screening</p>	<p>§ 3221(l)(11) § 4303(p)</p>	<p>This policy or contract form includes the following coverage for mammography screening for occult breast cancer:</p>	<p>page 22</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<ul style="list-style-type: none"> • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	
<p>Family Planning & Reproductive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines</p>	<p>This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.</p> <p>This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 22</p>
<p>Bone Mineral Density Measurements or Tests, Drugs and Devices</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language</p>	<p>This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis. <p>Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance</p>	<p>page 23</p>
<p>Prostate Cancer Screening</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(11-a) § 4303(z-1) Model Language</p>	<p>This policy or contract form includes coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<ul style="list-style-type: none"> An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	
EMERGENCY SERVICES AND URGENT CARE			
<p>Pre-Hospital Emergency Medical and Ambulance Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(15) § 4303(aa) Model Language</p>	<p><u>Emergency Medical and Ambulance Services:</u> This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person’s bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person.</p> <p>An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization.</p> <p><u>Non-Emergency Ambulance Services:</u> This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:</p> <ul style="list-style-type: none"> From a Non-Participating Hospital to a Participating Hospital. To a Hospital that provides a higher level of care that was not available at the original Hospital. To a more cost-effective acute care facility. From an acute facility to a sub-acute setting. 	<p>page 23</p>
<p>Emergency Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1</p>	<p>This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities:</p> <ul style="list-style-type: none"> without the need for any prior authorization; regardless of whether the provider is a participating provider; without imposing any administrative requirement or limitation on out-of-network coverage 	<p>page 26</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

	<p>(2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR § 147.138(b) 45 CFR § 156.100 Model Language</p>	<p>that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers;</p> <ul style="list-style-type: none"> • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. <p><i>Note the following definitions must be used:</i> <i>Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.</i></p> <p><i>Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph “to stabilize” means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).</i></p>	
<p>Urgent Care Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100</p>	<p>This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.</p>	<p>page 28</p>
<p>OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES</p>			
<p>Advanced Imaging</p>	<p>45 CFR § 156.100</p>	<p>This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 29
Allergy Testing and Treatment Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 29
Ambulatory Surgery Center Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 29
Chemotherapy Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 29
Chiropractic Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(k)(11) §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. <i>Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i>	page 29
Dialysis Coverage	§3221(k)(16) §4303(gg)	This policy or contract form provides coverage for dialysis treatment of an acute or chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis	page 29

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>treatment or services provided by a non-participating provider must be covered if the following conditions are met:</p> <ul style="list-style-type: none"> • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. <p>Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.</p>	
<p>Outpatient Habilitative Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.</p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 30</p>

Benefit explanation:

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Home Health Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(1) §4303(a)(3) Model Language</p>	<p>This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit <p>Such coverage may be subject to an annual deductible of not more than \$50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.</p>	<p>page 30</p>
<p>Interruption of Pregnancy</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year.</p> <p><i>Note: Plans must include the one procedure limit and may provide coverage that is more favorable.</i></p>	<p>page 30</p>
<p>Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(6) 4303(s) 11 NYCRR 52.18(a)(10) Definition of Infertility OGC Opinion 05-11-10 Model Language</p>	<p>This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility.</p> <ul style="list-style-type: none"> • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; 	<p>page 30</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	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.	page 31
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for 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.	page 31
Office Visits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for 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.	page 32
Outpatient Hospital Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for 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.	page 32
Preadmission Testing Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§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.	page 32
Outpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	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. <i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i> Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has	page 32

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.</p>		<p>undergone surgery for such illness or injury.</p> <p>Speech, physical and occupational therapy services must begin within six months of the later to occur:</p> <ul style="list-style-type: none"> • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. <p>In no event will the therapy continue beyond 365 days after such event.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: Plans may: increase the number of covered visits; cover 60 or more visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.</i></p>	
<p><u>Benefit explanation:</u></p>			
<p>Second Medical Opinion for Cancer Diagnosis</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(9) §4303(w) Model Language</p>	<p>This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.</p> <ul style="list-style-type: none"> • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	<p>page 33</p>
<p>Second Surgical Opinion</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(3) 4303(b) Circular Letter No. 29 (1979) Model Language</p>	<p>This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 33</p>
<p>Mandatory Second Surgical Opinion</p>	<p>§3221(k)(3) 4303(b)</p>	<p>The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979).</p>	<p>page 33</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Circular Letter No. 29 (1979) Model Language</p>	<p>Such coverage may not be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Second Opinion in Other Cases Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider’s recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 33</p>
<p>Surgical Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 11 NYCRR § 52.6 Model Language</p>	<p>This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician’s assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 33</p>
<p>Oral Surgery Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 11 NYCRR § 52.16(c)(9) Model Language</p>	<p>This policy or contract form provides coverage for the following limited dental and oral surgical procedures:</p> <ul style="list-style-type: none"> • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 33</p>
<p>Mastectomy Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(8) §4303(v) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	<p>page 34</p>
<p>Post Mastectomy Reconstruction</p>	<p>§3221(k)(10) §4303(x) Women’s Health and</p>	<p>This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a</p>	<p>page 34</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.</p>	
<p>Transplants Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 34</p>
<p>Autism Spectrum Disorder Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(l)(17) §4303(ee) Model Language 11 NYCRR 440</p>	<p>This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy or contract provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. <p>This policy or contract form shall include a definition of “autism spectrum disorder” which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).</p> <p>The policy or contract form shall include a definition of “behavioral health treatment” which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p> <p>The policy or contract form shall include coverage for “applied behavior analysis” which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year.</p>	<p>page 36</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<p>The policy or contract form shall include a definition of “assistive communication devices” which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	
<p>Diabetes Equipment, Supplies and Self-Management Education</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(7) §4303(u) 10NYCRR60-3.1 Model Language</p>	<p>This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3221(k)(7) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits.</p> <p><i>Note: Plans may apply either a medical or a prescription benefit depending upon whichever will provide a more generous benefit.</i></p> <p><i>Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy or contract form may not limit coverage to care prescribed by a physician.</i></p>	<p>page 38</p>
<p>Durable Medical Equipment and Braces</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 39</p>
<p>Hearing Aids</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.</p> <p>Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. <i>{Note: The three year limit on hearing aids is required for plans but the limit may be removed or modified so that coverage is more favorable.}</i></p> <p>Bone anchored hearing aids must be covered only if an insured has either of the following:</p> <ul style="list-style-type: none"> • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. <p>Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for</p>	<p>page 39</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Hospital Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.5 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including:</p> <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 42</p>
<p>Maternity Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(5) 4303(c) Model Language</p>	<p>This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3221(k)(1), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance.</p> <p>Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951.</p> <p>Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.</p>	<p>page 42</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 43
Inpatient Rehabilitative Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. <i>Note: Plans must cover 60 days; however plans may exceed the required 60 day, and also may remove the "per condition" and/or "per lifetime" limit.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</i>	page 43
<u>Benefit explanation:</u>			
Skilled Nursing Facility Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(l)(2) §4303(d) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. <i>Note: Plans must cover 200 days, but may cover more than 200 days.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance.	page 43
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.	page 44

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member’s own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p> <p><i>Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
PRESCRIPTION DRUGS			
<p>Prescription Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription” so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the same number of prescription drugs in each category and class as the benchmark plan.</p> <p>This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>page 47</p>
<p>Enteral Formulas</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(11) §4303(y) OGC Opinion 10-12-03 Model Language</p>	<p>This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited</p>	<p>page 47</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Off-Label Cancer Drug Usage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(l)(12) §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard’s Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	page 47
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	page 49
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).	no Tier 4
Eye Drops Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(k)(17) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	page 48
Orally Administered Anticancer Medications Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(l)(12-a) §4303(q-1) Model Language	The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that apply to coverage for intravenous or injected anticancer medications.	page 48
Mail Order Drugs for Policies With a Provider Network Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(l)(18) §4303(hh) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured’s option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	page 55
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	page 48; bracketed to be removed for religious groups

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		must be provided with no cost-sharing. <i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law...", the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.</i>	
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.</i> Are additional benefits being added to this EHB category? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, please explain how this substitution or addition differs from the Model Language benefit in the space provided.	45 CFR § 156.100 §3239 Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of \$200.00 for the subscriber and \$100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. <i>Note: Plans may offer more comprehensive coverage or may substitute this benefit.</i>	page 57
<u>Benefit explanation:</u> Member must complete 35 visits to fitness facility; \$200 reimbursement per 6 months for subscriber, spouse and eligible dependents age 18 and over, no annual maximum			
Other Wellness Benefits	45 CFR § 156.100 §3239	Additional Wellness Benefits may be covered. All additional wellness benefits <u>must</u> comply with § 3239 of Insurance Law.	page 57
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,	page 59

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p>preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>We are extending Vision coverage to include Adult</p>
DENTAL CARE			
<p>Pediatric Dental Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Is dental coverage being provided by the insurer in this filing? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>If No, please provide information in the explanation box below as to how the insurer is meeting the requirement to offer the pediatric essential health benefit.</p>	<p>45 CFR § 156.100 45 CFR § 156.150</p> <p>Model Language</p>	<p>This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: Insurers are required to offer the pediatric dental essential health benefit as either an embedded benefit (coverage provided by the insurer) or bundled benefit (coverage provided through an arrangement with another insurer).</i></p> <p><i>Embedded pediatric dental benefits must comply with all of the market reform and rating rules such guaranteed availability, rating tiers, rating regions, etc. For rating purposes, the pediatric dental benefit would be included in the insurer's single risk pool, medical loss ratio calculations and actuarial value calculations. Expenses related to an embedded pediatric dental benefit must also be included as part of the calculation of deductibles and out of pocket expense maximums.</i></p> <p><i>If the insurer offers a bundled stand-alone pediatric dental benefit, the following conditions must all be met:</i></p> <ul style="list-style-type: none"> • <i>The bundled dental benefit is identical to a stand-alone dental plan offered by the same dental carrier that is certified by the Exchange but offered outside the Exchange, including at the same premiums;</i> • <i>The policyholder or contractholder is informed that the dental benefit is being offered by a separate insurer, even if only one issuer collects the premiums;</i> • <i>The policyholder or contractholder is clearly informed of the medical plan design and the dental plan design and that the two plan designs have different deductibles, cost sharing and OOP maximums;</i> • <i>The policyholder or contractholder is clearly informed that they can purchase any stand-alone dental plan, other than the bundled dental plan, that has been certified by the Exchange but offered outside the Exchange.</i> • <i>The pediatric dental benefit meets the 70% or 85% actuarial value and \$700 OOP maximum for one covered child (or \$1,400 if more than one child in the family is covered);</i> 	<p>page 60</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<ul style="list-style-type: none"> • <i>The stand alone dental plan complies with all ACA provisions and CMS regulations pertaining to stand alone dental plans;</i> • <i>Insurers should specifically describe the legal and business arrangement between the medical issuer and the dental issuer when submitting the forms and rates to DFS, and each insurer must separately submit its own forms and rates for approval.</i> <p><i>If the insurer is reasonably assured that an individual has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange the insurer does not need to provide the dental benefit when coverage is issued. Insurers may include a question in their application/enrollment form in order to verify whether an insured has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange</i></p>	
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Explanation:

We are submitting 2 versions of dental coverage: pediatric and family. We are also bracketing the entire dental section in preparation for the potential removal of the benefit based on the Department's decision after reviewing all Small Group product submissions and whether or not adequate stand alone Dental options are available in the market.

ADDITIONAL BENEFITS			
Family Vision Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	page 59
Orthotics Model Language Used? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	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.	not covered
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If additional benefits are provided, please explain in box below.	http://public.leginfo.state.ny.us/menugtf.cgi?COMMONQUER Y=LAWS11 NYCR 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.	none

Explanation:

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

Acupuncture		This policy or contract form provides coverage for acupuncture.	
MAKE AVAILABLE BENEFITS			
Care in a Nursing Home or Skilled Nursing Facility	§ 3221(1)(2) § 4303(d)	This policy or contract must make available coverage for care in a nursing home, as defined by Public Health Law §2801, or a skilled nursing facility as defined in 42 USC §§1395, when such services are preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.	variability included in all SOBs to accommodate 2015 department
Licensed Clinical Social Worker	§ 3221(1)(4) § 4303(i)	If this policy or contract provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments by physicians, psychiatrists or psychologists, the policy or contract must make available and if requested by the policyholder, provide the same coverage to insureds for the such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to Article 154 of the Education Law (Education Law § 7700 et seq.).	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.</i> <i>The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.</i>	Form/Page/Para Reference
Aviation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	page 62
Convalescent and Custodial Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.	page 62
Cosmetic Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	page 62
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	page 62
Dental Services	11NYCRR52.16(c)(9)	This policy or contract form excludes coverage for dental services except for: care or treatment due to	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>) Model Language	accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	page 62
Experimental or Investigational Treatment. Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(k)(12) § 4303(z) Article 49 Model Language	This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.	page 62
Felony Participation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	page 62
Foot Care Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(6)) Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	page 63
Government Facility Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	page 63
Medically Necessary Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent certified by the State.	page 63
Medicare or Other Governmental Program Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	page 63
Military Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	page 63
No-Fault Automobile Insurance Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	page 63

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

Services Separately Billed by Hospital Employees Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	page 63
Services Provided by a Family Member Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	page 63
Services With No Charge Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	page 63
Services not Listed Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy or contract form as being covered.	page 63
Vision Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	page 63
Workers' Compensation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(8)) Model Language	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	page 63
War Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	page 64
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(a)(8) Model Language	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	page 65
Submission of Claim Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(a)(9) §4305(m) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	page 65

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
<p>Grievance Procedures</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§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</p>	<p>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:</p> <ul style="list-style-type: none"> • the right to file a grievance regarding any dispute between an insured and the insurer; • the right to file a grievance orally when the dispute is about referrals or covered benefits; • the toll-free telephone number which insureds may use to file an oral grievance; • the timeframes and circumstances for expedited and standard grievances; • the right to appeal a grievance determination and the procedures for filing such an appeal; • the timeframes and circumstances for expedited and standard appeals; • the right to designate a representative; • a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 	<p>page 67</p>
<p>Utilization Review Policies and Procedures</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§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</p>	<p>This policy or contract form includes a description of the utilization review policies and procedures, including:</p> <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; • the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any. 	<p>page 70</p>
<p>External Appeal Procedures</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language</p>	<p>This policy or contract form includes a description of the external appeal procedures, including:</p> <ul style="list-style-type: none"> • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal. 	<p>page 74</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

<p>COORDINATION OF BENEFITS</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.23 Model Language</p>	<p>If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.</p>	<p>Form/Page/Para Reference</p>
<p>TERMINATION OF COVERAGE</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p><i>The following are the only termination provisions permissible under the Insurance Law.</i></p>	<p>Form/Page/Para Reference</p>
<p>Notice of Termination</p>	<p>11 NYCRR 52.18(c)</p>	<p>Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.</p>	<p>page 81</p>
<p>Termination for Failure to Pay Premiums</p>	<p>§3221(p)(2)(A) §4305(j)(2)(A)</p>	<p>This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments.</p>	<p>page 81</p>
<p>Termination for Fraud</p>	<p>§3221(p)(2)(B) §4305(j)(2)(B) §3105</p>	<p>This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or a subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.</p>	<p>page 81</p>
<p>Termination for Failure to Comply With a Material Plan Provision</p>	<p>§3221(p)(2)(C) §4305(j)(2)(C)</p>	<p>This policy or contract form (other than a HMO) includes a provision permitting the insurer to terminate coverage if the group has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.</p>	<p>page 81</p>
<p>Discontinuation of a Class of Coverage</p>	<p>§3221(p)(2)(D); §3221(p)(3)(A) §4305(j)(2)(D) §4305(j)(3)(A)</p>	<p>This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each group, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer groups the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those groups or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.</p>	<p>page 81</p>
<p>Discontinuation of all Policies/Contracts in the Small Market</p>	<p>§3221(p)(2)(D); §3221(p)(3)(B) §4305(j)(2)(D) §4305(j)(3)(B)</p>	<p>This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the small group market upon written notice to the superintendent and to each group, participant, and beneficiary at least 180 days prior to the date of discontinuance.</p>	<p>page 81</p>
<p>Termination for Failure to Meet Requirements of Group</p>	<p>§3221(p)(2)(E); §4235(c)(1) §4305(j)(2)(E)</p>	<p>This policy or contract form includes a provision permitting the insurer to terminate coverage if the group ceases to meet the requirements of a group under §4235. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.</p>	<p>page 82</p>
<p>Termination if there are No Longer Insureds in the Insurer's Service Area</p>	<p>§3221(p)(2)(F) §4305(j)(2)(F)</p>	<p>This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.</p>	<p>page 82</p>
<p>Termination for Spouses in cases of divorce</p>		<p>This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.</p>	<p>page 81</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

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.	page 81
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.	page 81
Rescission Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	page 81
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.	page 81
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.	page 81
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.18(b)(4); (5); and (6) Model Language	This policy or contract form provides that when coverage under this policy or contract form ends, benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability. If the covered persons' coverage terminates by reason of the termination of active employment, an extended benefit will be proved during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.	page 83
Continuation Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(e)(11) §3221(m) §4305(e) COBRA, Title X of Public Law 99-272 Model Language	This policy or contract form contains a provision regarding continuation coverage. §§3221(m) and 4305(e) provide continuation coverage in circumstances when federal COBRA requirements do not apply, including for groups under 20 and upon application of the employee or member to continue hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents. An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by the group. The Insurance Law permits the group to charge an additional 2% administrative fee for continued coverage.	page 84

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<p>The continuation benefits terminate:</p> <ul style="list-style-type: none"> • 36 months after the date the employee or member’s benefits would otherwise have terminated because of termination of employment or membership. • In the case of an eligible dependent, 36 months after the date such person’s benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy or contract. • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage. • The end of the period for which premiums were made if the employee or member fails to make timely payment. 	
<p>Young Adult Option Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(r) §4305(l) Model Language</p>	<p>This policy or contract form provides notice of a young adult’s right, through the age of 29 (up to age 30), to independently purchase coverage through a parent group member’s policy or contract, regardless of whether the parent’s coverage includes coverage for dependents, as described in 3221(r), and/or 4305(l). If a young adult or the young adult’s parent elects this coverage, the young adult is issued a separate individual policy or contract.</p> <p>The insurer must comply with the notice requirements to each employee or member as set forth in 3221(r), and/or 4305(l).</p>	<p>page 86</p>
<p>Suspension of Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language</p>	<p>This policy or contract form provides that:</p> <ul style="list-style-type: none"> • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension. 	<p>page 85</p>
<p>Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard</p>	<p>§3221(n) §§4305(g); (h) Circular Letter No. 7 (2003) Model Language</p>	<p>If the group does not choose to voluntarily maintain coverage for any employee or member of when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.</p>	<p>page 85</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Conversion - Right to a New Contract After Termination Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(e) §4303(d)	<p>This policy or contract form provides that if the employee under the group contract ceases to be covered because of termination of coverage because of: (1) termination for any reason of his employment, or (2) termination for any reason whatsoever of the group policy or contract itself, unless the group policy or contract holder has replaced the group policy or contract with similar and continuous coverage for the same group, such employee shall be entitled to a new policy or contract as a direct pay member, covering such member and his eligible dependents.</p> <p>Conversion must also be made available, upon the death of the employee, to the surviving spouse and dependents, and the former spouse of the employee upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract or whose young adult coverage terminates.</p> <p>The policy or contract form provides that the employee or his eligible dependents must request conversion within sixty days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. The employee or his eligible dependents must also pay the first premium of the new contract at the time they apply for coverage.</p> <p>Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.</p>	page 87
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(a)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	page 90
Changes Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(a)(2) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the group and insurer.	page 89
Action in Law or Equity Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(a)(14) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy or contract.	page 89
Subrogation Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	page 92

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

	Model Language		
Unilateral Modification Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.18(a)(8) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the group. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the group to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such group no less than 14 days prior to the date by which the group is required to provide notice to terminate coverage.	page 89
Non-English Speaking Insureds Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	page 93
SCHEDULE OF BENEFITS Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract must contain a Schedule of Benefits. All services subject to preauthorization must be clearly indicated in the Schedule of Benefits.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	
Limitations on Annual Dollar Limits Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not impose “restricted” annual dollar limits for essential health benefits.	
Insured’s Financial Responsibility for Payment	§3217-a(a)(5) §4324(a)(5) PHL §4408(1)(e)	This policy or contract form includes a description of the insured’s financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured’s financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> If Out-of-Network coverage is offered please answer the following:	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. <i>Note: The Department will not permit more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i>	not applicable no out of network benefits

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract <input type="checkbox"/> Rider <input type="checkbox"/>			
Extended Dependent Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§4235(f)(1)(B) §4305(c)(1) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in §§ 4235(f) or 4305(c)(1).	See RIDER_Age 29-42
Contraceptive Drugs and Devices and Family Planning Services	§3221(l)(16)	This policy or contract form includes a rider for situations when a Group has elected not to purchase coverage for contraceptive drugs or devices pursuant to the religious employer exemption pursuant to §§3221(l)(16)(A); 4303(cc)(1)(A). In accordance with law, if elected by an insured, this Rider amends the policy or contract and provides coverage for contraceptive drugs or devices or generic equivalents approved as substitutes by the federal food and drug administration and provides coverage for family planning services.	see RIDER_WPS-42
<p>PROVIDER NETWORKS</p> <p>Has network been submitted to and/or approved by the Department of Health or the Exchange? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please indicate the name of the network, the network ID number, and the dates that the network was submitted to and/or approved by the Department of Health or the Exchange.</p> <p>Network Name:</p> <p>Network ID #:</p> <p>Date Submitted:</p> <p>Date Approved:</p>	§3201(c)	<p>If the insurance (other than HMO) policy or contract will be used in conjunction with a provider network, please identify in the adjacent box whether the insurer is using the same network that was submitted to and/or approved by the Department of Health and/or the Exchange. Please indicate the network name and network ID number and include the date that the network was submitted to and/or approved by the Department of Health and/or the Exchange.</p> <p>If the network differs in any respect from that which was submitted to and/or approved by the Department of Health and/or the Exchange, please provide details on how the network differs in the Supporting Documentation Tab in SERFF. This includes, but is not limited to, detailing the providers and specialty types in each county that differ from the network that was submitted to and/or approved by the Department of Health and/or the Exchange .</p> <p>In addition, the following items or information must be submitted as part of this filing:</p> <ul style="list-style-type: none"> • Participating provider directory; • Whether the provider network is capitated; • Provider selection criteria; • Quality assurance procedures; • Breakdown of geographic service area by county; • The underlying assumptions for the network regarding ratios of providers to insureds, the travel times and distances to participating providers; • Sample participating provider agreement; and, • Listing of providers by specialty type by county. <p><i>Note: The Department will not permit more than a 30% differential between in-network and out-of-</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<i>network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i>	
ACTUARIAL SECTION FOR <u>NEW PRODUCT</u> RATE FILINGS ONLY		<p>PLEASE NOTE: A new and detailed set of instructions “Instructions for the Submission of 2014 Premium Rates for SHOP On-Exchange Plans and Off-Exchange Plans” has been posted on the Department website and on SERFF.</p> <p><i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i> <p><i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i></p>	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	<p>Actuarial qualifications:</p> <ul style="list-style-type: none"> 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)	<p>Small Group:</p> <ul style="list-style-type: none"> 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 <input type="text"/> %. 	
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	<ul style="list-style-type: none"> a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans” as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. 	
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: <input type="text"/> %.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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

		<ul style="list-style-type: none">c. Insurer name on each consecutively numbered rate page.d. Identification by form number of each policy, rider, or endorsement to which the rates apply.e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits.f. Description of revised rating classes, factors and discounts.g. Examples of rate calculations.h. Commission schedule(s) and fees.i. Underwriting guidelines and/or underwriting manual.j. Expected loss ratio(s).	
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Empire HealthChoice Assurance, Inc.

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

<u>Form #</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables</u>	<u>Flesch</u>	<u>Score</u>
S_NY_EPO-R2fS2_GA_C_012014	9	3209	2.0	24.1	
S_NY_EPO_R2fS2_GA_B_012014	9	3209	2.0	24.1	
S_NY_EPO_R3S15-HSA_GA_B_012014	9	3209	2.0	24.1	
B_NY_EPO_R3bB4-HSA_GA_B_012014	9	3209	2.0	24.1	
B_NY_EPO_R3bB6-HSA_GA_B_012014	9	3209	2.0	24.1	
NY_EPO_GA_012014	1346	35197	1.68	42.7	
NY_GRP CONT-42	223	5610	1.62	46.1	
RIDER_WPS-42	16	310	1.7	43	
RIDER_Age 29-42	10	255	1.4	55.7	


Assistant Secretary

 Officer's Name Officer's Title

DATE: May 15, 2013

FOR INTERNAL USE ONLY

Memorandum of Variable Language Explanation

SERFF Filings:

Art 44 – HMO – AWLP-129002174

Art 42 – EPO – AWLP-129023432

Master Group Contract:

NY_GRP CONT-42

NY_GRP CONT -44

Certificates of Coverage (COC):

NY_EPO_GA_012014

NY_HMO_GA_012014

Schedules of Benefits:

1. B_NY_EPO_R3bB6-HSA_GA_B_012014
2. B_NY_EPO_R3bB4-HSA_GA_B_012014
3. S_NY_EPO_R3S15-HSA_GA_B_012014
4. S_NY_EPO_R2fS2_GA_C_012014
5. S_NY_EPO_R2fS2_GA_B_012014
6. G_NY_HMO_R3G6-HSA_GA_B_012014
7. G_NY_HMO-HNY_012014

Optional Riders:

RIDER-Age 29-42

RIDER-Age 29-44

RIDER-WPS-42

RIDER-WPS-44

The following is an explanation of the usage of the variable language contained in the above-referenced rider:

- Logo: The Company name and logo that appears in the upper left corner of the form will be either Empire Blue Cross Blue Shield or Empire Blue Cross depending on the geographic region of New York State in which the form will be issued. Empire Blue Cross Blue Shield's license agreement with the Blue Cross Blue Shield Association requires that the "Blue Cross" and "Blue Shield" portions of the name and logo be restricted to use in only certain New York State counties within its service area.
- Name of Group Contractholder: Will be customized upon distribution.
- Signature Block: The name, title, and signature of the signing Company officers may be changed from time to time to reflect the persons signing on behalf of the Company at the time the form is issued.
- [XXXX] in bottom right corner, reserved for Company use, related to fulfillment purposes.
- Network Name: We are submitting these products using Empire's "Pathway" Network. The Provider network that will support delivery of services under the products being filed herein, is the same network that Empire filed on 4/30/13 and is currently under review by the DOH.
- Company Information: The following information is bracketed: Company Address, Mailing Addresses, Member Services telephone number and hours of operation. Should the information change in the future, Empire will submit the appropriate filing to the Department, and upon approval, the Forms will be revised with the new information throughout the Certificate. Please note that all references to calling Member Services has been consistent throughout the Certificate as "the telephone number on the back of your ID card."

- **CLAIMS**
[Empire Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008]
*Submit claim forms to this address.
- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**
Telephone number: [1-800-635-5605]

[For Mental Health services, please send to:
Grievance and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473]

[For all other services, send to:
Empire Grievances and Appeals Department
P.O. Box 11825
Mail Drop R/5D
Albany, NY 12211]
- **MEMBER SERVICES**
[1-800-453-0113]
[Member Services Representatives are available [Monday – Friday 8:30 a.m. – 5:00 p.m. E.S.T.]]
- **PREAUTHORIZATION**
[1-800-982-8089]

Variability contained within the attached forms (contained within brackets)

Bracketed language or numbers are intended to represent all choices available; however, only one choice will be selected. The standard choice will be indicated in this Explanation Document. In some cases, we may provide an exception to our standard from the alternatives provided in the filing.

Bracketed language or numbers that do not apply to the Employer’s Contract will be removed prior to printing the Contract applicable to a specific group.

We may change the Contract to correct any minor typographical or formatting errors that exist at the time of the policy filing.

- Domestic Partner Language – contained in definition of “Spouse” and eligibility requirements in the “Who Is Covered” section.
- Description of “Deductible,” “Prescription Drug Deductible” and “Out-of-Pocket Limit” – We have retained permissible variability to accommodate various product options. The applicable language will remain according to the product plan structure.
- Family Planning & Reproductive Health Services, Contraceptive, etc. – We have retained permissible variability to support qualifying groups that may opt out of such coverage. The language will remain for all other groups.

- Skilled Nursing Facility – Mandated make available 365 days benefit appears as an option on the Schedule of Benefits. The day maximum was removed from the text for ease of fulfillment purposes.
 - Member pay the difference Prescription Drug provision – Permissible variability retained for plan designs that include the provision of member paying the difference between the cost of the brand and generic drug when a member or physician request the brand name drug.
 - **Dental variability in HMO:** We are bracketing the entire dental section in preparation for the potential removal of the benefit based on the Department's decision after reviewing all Small Group product submissions and whether or not adequate stand alone Dental options are available in the market.
 - **Dental variability in EPO:** We are submitting 2 versions of dental coverage: pediatric and family. We are also bracketing the entire dental section in preparation for the potential removal of the benefit based on the Department's decision after reviewing all Small Group product submissions and whether or not adequate stand alone Dental options are available in the market.
 - **HMO ONLY:** Exercise Facility Reimbursement – Our HMO plan designs include the standard fitness reimbursement program, as well as a nonstandard program. The Schedule of Benefits lists the reimbursement amounts that apply to the specific plan.
-

Network:

The Provider network that will support delivery of services under the products being filed herein, is the same network that Empire filed on 4/30/13 and is currently under review by the DOH.

Applications:

Group and Member Applications will be submitted via separate filing.

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Empire HealthChoice Assurance, Inc.
State:	New York
HIOS Issuer ID:	44113
Market:	Small Group
Effective Date:	January 1, 2014

- Company Contact Information

Primary Contact Name:	[REDACTED]
Primary Contact Telephone Number:	[REDACTED]
Primary Contact Email Address:	[REDACTED]

2. Scope and Purpose of the Filing

To the best of Empire's knowledge and current understanding, this filing complies with the most recent regulations and related guidance. Empire's intention is to fully comply with all applicable laws and guidance; however, the regulatory framework continues to change and evolve rapidly. To the extent relevant rules or guidance on the rules are updated or changed, amendments to this filing may be required.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA). The rates will be in-force for effective dates on or after January 1, 2014. 2014 rate changes will be implemented quarterly as discussed in more detail in Section 10: Index Rate. These rates will apply to plans offered Off-Exchange. This rate filing is not intended to be used for other purposes.

Policy Form Number(s):	NY_EPO_GA_012014
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3. Description of How the Base Rate Is Determined

The development of the Base Rate is detailed in Exhibit A - Base Rate Development. Further details on how the base rate is developed can be found in Section 4: Credibility Manual Rate Development, Section 6: Risk Adjustment and Reinsurance, Section 7: Non-Benefit Expenses, Profit and Risk, and Section 8: Average 2014 Rating Factors. A description of the methodology used to determine the base rate is as follows:

- Small Group manual rates are developed based on historical experience of Grandfathered and Non-Grandfathered business.
- The experience data is normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period based on expected distribution of membership.
- The projected claims cost is calculated by adjusting the normalized claims for the impact of benefit changes, population morbidity, trend factors, other cost of care impacts and other claim adjustments.
- The projection period is February 1, 2014 - January 31, 2015.
- Adjustments for risk adjustment and reinsurance are applied to the projected claims cost.
- Non-benefit expenses, profit, and risk are applied to the projected claims cost to determine the required projection period premium.
- The average rating factors in the projection period are applied to the projection period premium to determine the base rate.
- The base rate represents an average benefit plan and area for a single adult.

Premiums at the contract type level are determined by multiplying the base rate by the applicable factor for each of the allowable rating criteria: benefit plan, area and family composition. An example of this calculation is shown in Exhibit N - Sample Rate Calculation.

4. Credibility Manual Rate Development

Experience developed and projected herein is Empire's total Small Group Business, as well as all of Healthy New York, based on benefit expense. The rate development is shown in Exhibit A - Base Rate Development.

- Source and Appropriateness of Experience Data Used

The source data underlying the development of the manual rate consists of claims for all Grandfathered and Non-Grandfathered Small Group business, as well as all of Healthy New York, incurred during the period November 1, 2011 – October 31, 2012 and paid through December 31, 2012. Completion factors are then applied to reflect additional months of runout after December 31, 2012.

Other than completing the incurred claims, no further explicit adjustments are made to the experience data.

For more detail, see Exhibit B - Claims Experience for Manual Rate Development.

- **Adjustments Made to the Data**

The development of the projected claims is summarized in Exhibit A - Base Rate Development, items (1) - (10), and described in detail below.

The projected claims cost is calculated by multiplying the normalized claims cost by the impact of benefit changes, anticipated changes in population morbidity, and cost of care impacts. The adjustments are described below, and the factors are presented in Exhibit D - Projection Period Adjustments.

Changes in Demographics (Normalization)

The source data was normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period. The purpose of these factors is to adjust current experience to be reflective of expected claim experience in the projection period. See Section 13: Membership Projections for additional information on membership movement. The normalization factors and their aggregate impact on the underlying experience data are detailed in Exhibit C - Normalization Factors.

- **Age/Gender:** The assumed claims cost is applied by age and gender to the experience period distribution and the projection period distribution. Age/gender factors are developed from Milliman data.
- **Area/Network:** The area claims factors are developed based on an analysis of Small Group allowed claims, mapped to the prescribed 2014 rating areas using 5-digit zip code.
- **Benefit Plan:** The experience period claims are normalized to an average 2014 plan using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements. The adjustments for anticipated changes in utilization are in accordance with the DFS Instructions for the submission of 2014 premium rates, Section 5: "Induced Demand."

Changes in Benefits

Benefit changes include the following:

- **Preventive Rx (over the counter):** The claims are adjusted for 100% coverage of benefits for specific over the counter drugs obtained with a prescription from a physician.
- **Rx Adjustments:** The claims are adjusted for differences in the Rx formulary, mandatory mail order programs, and impacts for moving drugs into different tiers in the projection period relative to what is reflected in the base experience data.

Changes in the Morbidity of the Population Insured

The claims are adjusted to reflect shifts in health insurance coverage as a result of the provisions of the ACA. The market shifts, or population movements, affecting the morbidity of the Small Group market in the projection period include:

- Small Groups electing to drop coverage
- Small Group members electing to be uninsured
- Small Group members moving to Medicaid

The movement assumptions above are based on market research and assumptions on the employer opt-out and consumer uptake rates. The morbidity impacts of population movement are based on health status determined from internal risk score data.

Trend Factors

- The annual pricing trend used in the development of the rates includes the underlying cost of care claims trend (including anticipated changes in provider contracts), which has been normalized for persistent business, age/gender, and large claims, plus an estimate for leveraging, aging and a provision for adverse deviation. The claims are trended 27 months from the midpoint of the experience period, which is May 1, 2012, to the midpoint of the projection period, which is August 1, 2014.
- Empire's overall pricing trend is approximately 11.1% and consists of the following components:
 - ✦ Underlying Trend: Empire's Cost of Care Actuaries calculate the underlying trend data. This trend excludes aging, leveraging and selection adjustments, but includes the impact of new technology and cost of care initiatives. The underlying trend is roughly 7%.
 - ✦ Aging Adjustment: The aging adjustment is just under 3%.
 - ✦ Cost Sharing Leveraging Adjustment: The cost sharing leveraging adjustment is roughly 1%.

Other Claim Adjustments

The adjustments described below are presented in Exhibit E - Other Claim Adjustments.

- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.

- The cost of adding benefits for pediatric dental, pediatric vision and gym membership are included.
- Covered Lives Assessment: This indirect New York tax is a charge on all fully and self insured “covered lives”. The purpose of the Covered Lives Assessment is to raise funds for a variety of state programs and for the state Budget. The Assessment is included in claims costs for purposes of calculating the MLR.
- Healthy New York Subsidy: The projected Regulation 171 recovery for high cost claimants in the Healthy New York policy.
- Additional Non-EHBs: Clinical packages including programs such as Future Moms, Nurse Line and Healthy Lifestyles

- Capitation Payments

The underlying data includes capitation payments, which are combined with the base medical and pharmacy claims and projected at the same rate. No further adjustment is made to the capitation.

5. Credibility of Experience

The combination of both Grandfathered and Non-Grandfathered experience data most reasonably reflects Small Group claims experience under the future projection period. Actuarial judgment has been exercised to determine that rates will be developed giving full credibility to the data underlying the rates in Section 4: Credibility Manual Rate Development.

6. Risk Adjustment and Reinsurance

- Projected Risk Adjustment

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, Empire is assuming the risk for the plans in this filing are in accordance with the New York DFS risk adjustment simulation. This simulation shows that the risk adjuster payment for small group business in the HMO company is 14.3% of claims, while the risk adjuster payment for small group business in the Assurance company is -0.7% of claims. The weighted average of these percentages, based on total claims, yields a risk adjuster payment of 3.5% of claims, which is equivalent to \$13.37 PMPM in 2014, as shown in Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments.

- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The transitional reinsurance risk mitigation program collects funds from all insurance issuers and TPAs and redistributes them to high cost claimants in the Non-Grandfathered Individual market. The reinsurance contribution is equal to the national per capita reinsurance contribution rate as shown in Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments.

7. Non-Benefit Expenses, Profit and Risk

Non-Benefit expenses are detailed in Exhibit G - Non-Benefit Expenses and Profit & Risk.

- Administrative Expense

Administrative Expense contains both acquisition costs associated with the production of new business through non-broker distribution channels (direct, telesales, etc) as well as maintenance costs associated with ongoing costs for the administration of the business. Acquisition costs are projected using historical cost per member sold amounts applied to future sales estimates. Maintenance costs are assumed to be flat on a per member basis with savings from fixed cost leverage and the elimination of underwriting offset by new expenses for risk management, regulatory compliance and premium reconciliation and balancing.

- Quality Improvement Expense

The quality improvement expense represents Empire's dedication to providing the highest standard of customer care and consistently seeking to improve health care quality, outcomes and value in a cost efficient manner.

See Exhibit H - Quality Improvement/Cost Containment Programs for a description of these programs.

- Selling Expense

Selling Expense represents broker commissions and bonuses associated with the broker distribution channel using projected commission levels.

Empire recently filed a commission schedule for 2014 Small Group business.

- Taxes and Fees

- Patient-Centered Outcomes Research Institute (PCORI) Fee: The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund. For plan years ending before October 1, 2014, the fee is \$2 per member per year. Thereafter, for every plan year ending before October 1, 2019, the fee will increase by the percentage increase in National Healthcare Expenditures.
- Risk Adjustment Fee: The Risk Adjustment fee is a user fee to support the administration of the HHS operated Risk Adjustment program. The charge is \$1 per enrollee per year.
- ACA Insurer Fee: The health insurance industry will be assessed a permanent fee, based on market share of net premium, which is not tax deductible.
- Federal, state, and premium taxes are also included in the retention items.

- Profit

Profit is reflected on a post-tax basis as a percent that does not vary by product or plan.

- Changes in Exhibit 9 (formerly Exhibit 2) Expense Components

Differences in expense components between the current Exhibit 9 for Exchange plans and the Exhibit 2 submitted for inforce plans in the most recent/current Sections 3231(e)(1)/4308(c) Rate Adjustment applications are as follows:

- Projected administrative expenses, as a proportion of premium, are similar to those represented in the most recent 4308(c) and 3231(e)(1) filings. Notable differences are the increased commission, consistent with Empire's recently filed 2014 small group commission schedule; and an increase in taxes corresponding to new PPACA-related fees.

- Reconciliation with Financial Statements

Projected administrative expenses, as a proportion of premium, are similar to those represented in the 2012 financial statements. Again, differences would reflect the increased commission, consistent with Empire's recently filed 2014 small group commission schedule; and an increase in taxes corresponding to new PPACA-related fees.

8. Average 2014 Rating Factors

The required premium in the projection period is adjusted to reflect the average benefit plan, area and family composition rating factors to develop the rating period base rate. The average factors are shown in Exhibit I - Average 2014 Rating Factors and applied in line item 14 of Exhibit A - Base Rate Development.

- Benefit Plan Factors

Refer to Exhibit J - Non-Grandfathered Benefit Plan Factors.

- Area Factors

Refer to Exhibit K - Area Factors.

- Family Composition Factors

Refer to Exhibit L - Family Composition Factors.

9. Projected Loss Ratio

- Projected Federal MLR

The projected Federal MLR for the products in this filing is estimated in Exhibit O - Federal MLR Estimated Calculation. Please note that this calculation is purely an estimate and not meant to be a true measure for Federal or State MLR rebate purposes. The products in this filing represent only a subset of Empire's Small Group business. The MLR for Empire's entire book of Small Group business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to third party margins, three-year averaging, credibility, dual option, and deductible. Empire's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

10. Index Rate

- Projection Period Index Rate

The index rate, as defined in the Federal regulations, represents the average allowed claims PMPM of essential health benefits for Empire's total Small Group Non-Grandfathered Business. The first quarter projection period index rate was developed as shown in Exhibit P - Projected Index Rate Development by adjusting the projected incurred claims PMPM described in Section 4: Credibility Manual Rate Development of this memorandum. Projected trended index rates by quarter are also captured in Exhibit R - Quarterly Index and Base Rate. No benefits in excess of the essential health benefits are included in the projection period allowed claims and Exhibit R's projection period index rate. To calculate the required premium, the projection period index rate is adjusted only by the adjustments allowed per Market Reform and Payment Parameters Regulations. This development is presented in Exhibit Q - Development of Required Premium from Index Rate.

- Quarterly Index and Base Rate

Quarterly index and base rate changes will be implemented. Refer to Exhibit R - Quarterly Index and Base Rate.

11. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values included in Addendum II - Listing of Plans in the Risk Pool are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially-equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. Benefits for Plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

The Actuarial Value (AV) Metal Values for inforce plans are determined in the same fashion.

12. Actuarial Value Pricing Values

The Initial Plan Pricing AVs in Addendum III - Development of Plan-Level Premium Rates by Census Tier are developed using WellPoint's benefit relativity factor model, which is a modified Milliman model. The program allows induced utilization to be turned off and the DFS' recommended induced utilization amounts were used.

13. Membership Projections

Membership projections are developed using a population movement model and adjustments for sales expectations. This model projects the membership in the projection period by taking into account:

- Small Groups dropping coverage
- Small Group members opting out of coverage
- Small Group members to Medicaid as a result of expanded Medicaid eligibility

The plan distribution is based on assumed metal tier and network distributions.

Refer to Exhibit D - Projection Period Adjustments for the projected morbidity changes from population movement.

14. Pricing of Make Available Riders

Pricing methods for each of the required make-available riders are discussed below:

- Domestic Partner Rider

This rider is currently offered at no additional cost because it is assumed that the use of the appropriate contract type will cover the cost of this additional member. Empire intends to continue that practice of no additional charge going forward.

- Unlimited SNF Days Rider

The filed 2014 rates for Empire's current Small Group products apply between 0.05% and 0.14% for this additional SNF coverage. Empire proposes a rate of 0.07% to increase SNF days to be unlimited going forward, which is a weighted average of the range.

- Dependent Coverage through the Age of 29 Rider

The filed 2014 rates for Empire's current Small Group products apply between 3% and 10% on the contract types that have children for this coverage. A predominance of these plans charge approximately 4%, so going forward Empire proposes a charge of 4% of parent/child(ren) and family contracts for this coverage, which is a weighted average of the range.

- Opt-out of Contraceptives Rider

An enterprise study determined that contraceptive benefits are worth about 0.7% of Empire's average claim PMPM as developed for 2014. Empire proposes a rate of 0.7% to remove contraceptive coverage.

- Member Opt-in of Contraceptives Coverage

For a Small Group that opts out of contraceptive coverage, the members may opt to purchase this coverage directly from Empire. Empire proposes a single rate of \$3.20 (which is $0.7\% * 382.04 * 1.1985 = \text{opt-out rate} * \text{line 10 from Exhibit A} * \text{result of Exhibit M}$) to add back contraceptive coverage, consistent with the average amount removed from the group's rate.

15. State Actuarial Memorandum Requirements

For a mapping of each Actuarial Memorandum Requirement of the State of New York to its location in this submitted Actuarial Memorandum, please refer to Addendum I - State Requirements.

For a listing of all plans included in the risk pool, refer to Addendum II - Listing of Plans in the Risk Pool.

For a development of plan-level premium rates in the format requested by the DFS, refer to Addendum III - Development of Plan-Level Premium Rates by Census Tier.

16. Actuarial Certification

I, [REDACTED] am an actuary for Empire. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The filing is in compliance with all applicable laws and regulations of the State of New York;

(2) The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

- ✦ ASOP No. 5, Incurred Health and Disability Claims
- ✦ ASOP No. 8, Regulatory Filings for Health Plan Entities
- ✦ ASOP No. 12, Risk Classification
- ✦ ASOP No. 23, Data Quality
- ✦ ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ✦ ASOP No. 41, Actuarial Communications

(3) The expected loss ratio incorporated into the rate tables meets the minimum

(4) The benefits are reasonable in relation to the premiums charged; and

(5) The rates are not unfairly discriminatory.

[REDACTED]

[REDACTED], MAAA
Regional Vice President and Actuary III

May 13, 2013

Date

Exhibit A - Base Rate Development

Effective January 1, 2014

Empire HealthChoice Assurance, Inc. Small Group

	<u>Paid Claims</u>	
1) Experience Period Cost PMPM	\$ 404.78	Exhibit B
2) x <u>Normalization Factor</u>	<u>0.7957</u>	Exhibit C
3) = Normalized Claims	\$ 322.08	= (1) x (2)
4) x Benefit Changes	0.9518	Exhibit D
5) x Morbidity Changes	1.0062	Exhibit D
6) x Medical Trend Factor	1.2669	Exhibit D
7) x <u>Other Cost of Care Impacts</u>	<u>1.0000</u>	Exhibit D
8) = Projected Claim Cost	\$ 390.78	= (3) x (4) x (5) x (6) x (7)
9) + Other Claim Impacts	(\$8.74)	Exhibit E
10) = Claims Projected to Projection Period	\$ 382.04	= (8) + (9)
11) + Risk Mitigation - Contributions and Payments	(\$8.27)	Exhibit F
12) + <u>Selling Expense, Administration and Other Retention Items {1}</u>	<u>\$79.21</u>	Exhibit G
13) = Required Premium in Projection Period	\$ 452.98	= (10) + (11) + (12)
14) (a) x Average Contract Size Factor in Projection Period	1.7630	Exhibit H
(b) ÷ Average Rating Factors (Rating Tier/Area/Plan) in Projection Period	1.4710	Exhibit H
15) = Base Rate (Average Plan-Level)	\$ 542.90	= (13) x (14a) ÷ (14b)
16) Projected Loss Ratio (Conventional Basis)	82.5%	= [(10) + (11)] ÷ (13)

NOTES:

{1} Equivalent to PMPM expenses on Exhibit G + % of premium expenses on Exhibit G applied to Required Premium (Row 13 above).

Exhibit B - Claims Experience for Manual Rate Development

Empire HealthChoice Assurance, Inc.
Small Group

Incurred November 1, 2011 through October 31, 2012
Paid through December 31, 2012

Healthy New York and SG HMO In-Area Business:

PAID CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
\$ 718,221,511	\$ 166,352,891	\$ 14,960,832	\$ 52,990	\$ 733,182,343	\$ 166,405,881	\$ 4,400,705	\$ 903,988,929	2,233,257	\$ 404.78	

ALLOWED CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
\$ 904,805,783	\$ 211,479,742	\$ 18,420,701	\$ 66,206	\$ 923,226,484	\$ 211,545,948	\$ 4,400,705	\$ 1,139,173,137	2,233,257	\$ 510.09	

Exhibit C - Normalization Factors

Empire HealthChoice Assurance, Inc.
Small Group

Experience Period: November 1, 2011 through October 31, 2012

<u>Normalize to population expected in 2014</u>			
<i>Average claim factors based on future population as compared to experience period population:</i>			
	Average Claim Factors		Normalization
	Experience Period Population	Future Population	Factor
Age/Gender	1.1055	1.1055	1.0000
Area/Network	1.0011	0.9106	0.9096
Benefit Plan	1.2194	1.0668	0.8748
Total	1.3495	1.0739	0.7957

Exhibit D - Projection Period Adjustments

Empire HealthChoice Assurance, Inc. Small Group

Impact of Changes Between Experience Period and Projection Period:

	<u>Adjustment Factor</u>
<u>Benefit changes</u>	
Preventive Rx (over the counter)	1.0005
Eliminate Pre-Ex	1.0000
<u>Rx Adjustments {1}</u>	<u>0.9513</u>
Total Benefit Changes	0.9518
<u>Morbidity changes</u>	
Total Morbidity Changes	1.0062
<u>Cost of care impacts</u>	
Annual Medical/Rx Trend Rate	11.09%
# Months of Projection	27
Trend Factor	1.2669

NOTES:

{1} Includes Rx formulary, mandatory mail order

Exhibit E - Other Claim Adjustments

Empire HealthChoice Assurance, Inc. Small Group

<i>Adjustments to projection period claims to reflect covered benefits not included in experience period data:</i>	
	<u>PMPM</u>
Rx Rebates	(\$7.20)
Pediatric Dental	\$3.62
Pediatric Vision	\$0.89
Gym Membership	\$0.99
Covered Lives Assessment	\$7.28
Healthy New York Subsidy	(\$18.04)
<u>Additional Non-EHBs {1}</u>	<u>\$3.72</u>
Total	(\$8.74)

{1} The 'Additional Non-EHBs' adjustment above reflects ONLY additional costs beyond those already captured in line Item 8 of Exhibit A. Line Item 8 of Exhibit A includes \$0.36 of embedded Non-EHB medical costs resulting from inclusion in the experience data and/or the normalization process.

Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments

Empire HealthChoice Assurance, Inc.
Small Group
Effective January 1, 2014

<u>Risk Adjustment:</u>			
Description	Transfers funds from lowest risk plans to highest risk plans		
Participants	Non-Grandfathered Individual and Small Group plans (inside and outside Exchange) are eligible		
PMPM	Net Transfer		
Federal Program	(\$13.37)		
	<u>Note:</u>		
	It is assumed the risk for the plans included in this rate filing is worse overall than other plans within this market.		
<u>Reinsurance:</u>			
Description	Provides funding to plans that enroll highest cost individuals		
Participants	All insurance issuers and TPAs contribute funds		
	Non-Grandfathered Individual plans (inside and outside Exchange) are eligible for payments		
PMPM	Contributions Made	Payments Received	
Federal Program	\$5.10	\$0.00	<i>Small Group Plans contribute funds but only Individual Plans are eligible to receive payments</i>
	<u>Source:</u>		
	HHS estimates a national per capita contribution rate of \$5.25 per month (\$63 per year) in benefit year 2014 (per Payment Parameter Rule).		
Grand Total of All Risk Mitigation Programs			(\$8.27)

NOTES:

$\$5.10 = \$5.25 * (11 \text{ months}/12\text{months}) + \$3.50 * (1 \text{ months}/12 \text{ months})$

\$5.25 = 2014 contribution

\$3.50 = 2015 contribution

Exhibit G - Non-Benefit Expenses and Profit & Risk

Empire HealthChoice Assurance, Inc. Small Group

	<u>PMPM</u>	<u>% Premium</u>
Administrative Costs	\$29.01	
Quality Improvement Expense	\$2.61	
Selling Expense	\$8.66	
ACA Related Fees:		
PCORI Fee	\$0.17	
Risk Adjustment User Fee	\$0.08	
ACA Insurer Fee		2.55%
Exchange User Fee		0.00%
Premium Tax		2.99%
Federal/State Taxes		1.05%
Profit (Post-Tax)		1.95%
Total	\$40.53	8.54%

Exhibit H - Quality Improvement/Cost Containment Programs

Empire HealthChoice Assurance, Inc. Small Group

Radiology and Cardiac	Prospective clinical appropriateness reviews for diagnostic imaging .
Specialty Pharmacy Program	Prospective clinical appropriateness reviews for specialty pharmaceuticals.
OptiNet	A web-based application supports collaboration and more informed decision-making by physicians and members when selecting diagnostic imaging facilities.
Specialty Care Shopper Program	A member-engagement program that aims to provide members with choices between high-cost and low-cost imaging facilities with equal or better quality by information sharing and proactive member call outs.
Sleep Program	A Sleep Medicine Management Program that conducts pre-service clinical appropriateness review.
Physical Therapy / Occupational Therapy (PT/OT) Management Program	The PT/OT Management program involves prior review of services with regard to established medical policy and clinical guidelines.
Discharge Planning	Discharge planning activities are comprehensive in nature and consist of organizing and transitioning care to lesser acute facilities, counseling patients on discharge instructions, care coordination, etc.
Care coordination	Nurses interface with the clinicians on a member's care team when members are admitted to the hospital.
Radiology Benefits Management Program	The Radiology Benefits Management program involves prior review of services with regard to established medical policy and clinical guidelines.
Pharmacy Prior Authorization	Prior authorization involves review of submitted pharmacy claims to ensure the intended use is FDA approved or recognized in a major compendia as being safe and effective in order to be a covered benefit.
Specialty Pharmacy Drug Reviews	Pre-certification process of specialty medications.
Care Management	Care management staff coordinates quality health care services and the optimization of benefits through a realistic, cost-effective, and timely care management plan.
ComplexCare	The ComplexCare program is a proactive, collaborative, member-centric model of care management in which chronic care management is emphasized for those members with chronic or multiple non-disease management types of condition(s) at future high risk.
ConditionCare (Disease Management) Program	A program to help maximize member health status, improve health outcomes, and control health care expenses associated with the following prevalent conditions: Asthma (pediatric and adult), Diabetes (pediatric and adult), Heart Failure (HF), Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD).
MyHealth Coach Program	MyHealth Coach nurses serve as a central point of contact for individuals who have questions about a health care related topic, condition or concern, a question about benefits, a concern about claim payment or language in an 'Explanation of Benefits' statement.
Chronic Kidney Disease	The Kidney Disease Management: Chronic Kidney Disease (late stage) and End Stage Renal Disease program is designed to Improve participant's quality of life and clinical outcomes, slowing the progression of the disease and controlling costs related to hospitalizations, emergency room admissions and significant complications.
Nurseline	24/7 NurseLine is staffed exclusively by Registered Nurses who assist consumers in choosing the most appropriate use of health care resources, applying self care, learning about specific medical conditions, treatment options and side effects associated with prescription drugs, and providing valuable lifestyle management and nutrition information.
Healthy Lifestyles	Lifestyle management/health & wellness program that includes web-based programs & tools, telephonic lifestyle coaching and access to a national network of fitness centers.
MyHealth Advantage (MHA)	MHA comprises quality-based communications to members, physicians, health care plans, and pharmacists (as needed) on topics such as best-practice therapeutic interventions in member medical care.
Health IT	IT expenses in support of the programs noted above which have been identified as executing Quality Improvement activities.
Chiropractic Benefit Management Program	The Chiropractic benefit Management program involves retrospective review of services with regard to established medical policy and clinical guidelines.
Gym Reimbursement Program	The Gym Reimbursement program involves partially reimbursing the Subscriber and the Subscriber's Covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities and which maintain equipment and programs that promote cardiovascular wellness.

Exhibit I - Average 2014 Rating Factors

Empire HealthChoice Assurance, Inc.
Small Group

Effective January 1, 2014

<i>Average 2014 rating factors for 2014 population:</i>	
	Average Rating Factor
Average Contract Size	1.7630
Contract Type	1.4710
Area	1.0000
Benefit Plan	1.0000
Total (Contract Type x Area x Benefit Plan) =	1.4710
Conversion Factor	1.1985

Exhibit J - Non-Grandfathered Benefit Plan Factors

Empire HealthChoice Assurance, Inc.

Small Group

Effective January 1, 2014

Off-Exchange Plans:		
<u>Metal Level</u>	<u>HIOS Standard Component Plan ID</u>	<u>Benefit Plan Factor</u>
Bronze	44113NY0380004	0.7740
	44113NY0380005	0.7294
	44113NY0380009	0.7740
	44113NY0380010	0.7294
Silver	44113NY0380002	0.9068
	44113NY0380003	0.9480
	44113NY0380001	0.8950
	44113NY0380007	0.9068
	44113NY0380008	0.9480
	44113NY0380006	0.8950
Gold	80519NY0200001	1.0751
	80519NY0080001	0.8987
	80519NY0200002	1.0751
	80519NY0080002	0.8987

Benefit Plan Factors above reflect plan by plan differences from the index rate for allowable adjustments as described in detail in the Market Reform and Payment Parameters Regulations and illustrated in Exhibit Q. The weighted average of these adjustments for the entire risk pool included in this rate filing is detailed in Exhibit I.

Exhibit K - Area Factors

Empire HealthChoice Assurance, Inc.
Small Group
Effective January 1, 2014

Rating Area Description	Narrow Rating Factor
Albany	0.9435
Long Island	0.9335
Mid-Hudson	1.1051
New York City	1.0332
Upstate	1.4043

NOTES:

{1} Network adjustments (e.g., discount differences) are included in the benefit plan factors as shown in Exhibit J.

Exhibit L - Family Composition Factors

Empire HealthChoice Assurance, Inc.

Small Group

Effective January 1, 2014

Contract Type	Composition Factor
Single	1.00
Single + Spouse	2.00
Single + Child(ren)	1.70
Single + Spouse + Child(ren)	2.85

Exhibit M - Development of Conversion Factor

Empire HealthChoice Assurance, Inc.

Small Group

Effective January 1, 2014

Contract Type	Projected Contract Distribution	a) Prescribed Premium Relativity	b) Average Contract Size	c) Conversion Factor: (a) ÷ (b)
Individual	65%	1.00	1.00	
Husband/Wife	14%	2.00	2.00	
Parent/Child(ren)	5%	1.70	2.90	
Family	16%	2.85	4.30	
All Contracts	100%	1.4710	1.7630	1.1985

Exhibit N - Sample Rate Calculation

Empire HealthChoice Assurance, Inc. Small Group

Group Name: Sample Group
Effective Date: 01/01/2014
On/Off Exchange: Off
Metal Level: Bronze
Plan ID: 44113NY0380004
Rating Area: Albany
Network: Narrow
Group Census:

Calculation of Monthly Premium:

Base Rate =	\$	542.90	Exhibit A
x Benefit Plan Factor		0.7740	Exhibit J
<u>x Area Factor</u>		<u>0.9435</u>	Exhibit K
Base Rate Adjusted for Plan/Area =	\$	396.46	

Final Monthly Premium PMPM:

<u>Contract Type</u>	<u>Family Composition Factor (Exhibit L)</u>	<u>Monthly Rate</u>
Single	1.00	\$ 396.46
Single + Spouse	2.00	\$ 792.92
Single + Child(ren)	1.70	\$ 673.98
Single + Spouse + Child(ren)	2.85	\$ 1,129.91

Exhibit O - Federal MLR Estimated Calculation

Empire HealthChoice Assurance, Inc. Small Group

Numerator:

Incurred Claims	\$382.04	Exhibit A
+ Quality Improvement Expense	\$2.61	Exhibit G
+ Risk Corridor Contributions	\$0.00	
+ Risk Adjustment Contributions	\$0.00	Exhibit F
- Reinsurance Receipts	\$0.00	Exhibit F
- Risk Corridor Receipts:	\$0.00	
<u>- Risk Adjustment Receipts:</u>	<u>\$13.37</u>	Exhibit F
= <i>Estimated Federal MLR Numerator</i>	\$371.28	

Denominator:

Premiums	\$452.98	Exhibit A
- Federal and State Taxes	\$4.76	Exhibit A (Premium) and Exhibit G (Taxes)
- Premium Taxes	\$13.54	Exhibit A (Premium) and Exhibit G (Taxes)
- Reinsurance Contributions	\$5.10	Exhibit F
<u>- Licensing and Regulatory Fees</u>	<u>\$11.80</u>	Exhibit A (Premium) and Exhibit G (Fees)
= <i>Estimated Federal MLR Denominator</i>	\$417.78	

Estimated Federal MLR

88.87%

NOTES:

The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

- 1) The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.
- 2) Not all numerator/denominator components are captured above (for example, third party vendors excess reimbursement, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).
- 3) Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.
- 4) Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule

Exhibit P - Projected Index Rate Development

Effective January 1, 2014

Empire HealthChoice Assurance, Inc.
Small Group

1) Projected Paid Claim Cost	\$	390.78	Exhibit A, Line Item 8
2) <u>- Non-EHBs Embedded in Line Item 1) Above</u>		<u>\$0.36</u>	Exhibit E (see footnote in Exhibit E)
3) = Projected Paid Claims, Excluding ALL Non-EHBs	\$	390.42	
4) + Rx Rebates		(\$7.20)	Exhibit E
5) <u>+ Additional EHBs {1}</u>		<u>\$5.50</u>	Exhibit E
6) = Projected Paid Claims Reflecting <i>only</i> EHBs	\$	388.72	
7) <u>÷ Paid to Allowed Ratio</u>		<u>0.7576</u>	
8) = Projected Allowed Claims Reflecting <i>only</i> EHBs		\$513.09	= Index Rate

NOTE:

{1} Pediatric Dental, Pediatric Vision and Gym

Exhibit Q - Development of Required Premium from Index Rate

Effective January 1, 2014

Empire HealthChoice Assurance, Inc. Small Group

	<u>Weighted Average for Risk Pool</u>	
1) Index Rate - Federal Definition	\$513.09	Exhibit P
2) <u>x Paid to Allowed Ratio</u>	<u>0.7576</u>	Exhibit P
3) = Projected Paid Claims Reflecting <i>only</i> EHBs	\$388.72	
<u>Allowable Index Rate Adjustments {1} {2}: </u>		
4) x Benefit Adjustments	1.0000	
5) + Non-EHBs	(\$6.68)	Exhibit E
6) x Catastrophic Adjustment	1.0000	
7) x Network Adjustment	1.0000	
8) + Risk Mitigation - Contributions and Payments	(\$8.27)	Exhibit F
9) + <u>Selling Expense, Administration and Other Retention Items</u>	<u>\$79.21</u>	Exhibit G (also see Exhibit A, Line item 12)
10) = Required Premium in Projection Period	\$452.98	Ties to Exhibit A, Line item 13

NOTES:

- {1} Allowable adjustments to the index rate as made above are in accordance with the Market Reform and Payment Parameters Regulations.
- {2} The above illustrates the allowable adjustments to the average single risk pool index rate as included in this rate filing. These adjustments may vary on a plan by plan basis and such variances are captured in the benefit plan factors as summarized in Exhibit J.
- {3} Plan-level rates are obtained by multiplying the base rate as shown in line item 15 of Exhibit A by the benefit plan factors illustrated in Exhibit J. Further allowable adjustments (area and family composition) are applied to arrive at final premium rates.

Exhibit R - Quarterly Index and Base Rate

Empire HealthChoice Assurance, Inc. Small Group

	Rates Effective:				
	1Q14	2Q14	3Q14	4Q14	Wtd Avg
Renewing Member Months	558,314	558,314	558,314	558,314	2,233,257
Quarterly Allowed Trend		2.43%	2.43%	2.43%	
Index Rate	\$513.09	\$ 525.56	\$ 538.33	\$ 551.41	\$ 532.10
Quarterly Paid Trend		2.80%	2.80%	2.80%	
Base Rate	542.9	\$ 558.10	\$ 573.73	\$ 589.79	

NOTES:

{1} The 1Q14 index rate was derived in Exhibit P.

{2} The 1Q14 index rate is assumed to increase with quarterly allowed trend as illustrated above.

{3} The 1Q14 base rate was derived in Exhibit A.

{4} The 1Q14 base rate is assumed to increase with quarterly paid trend as illustrated above. This trend rate differs from the index rate trend in that it includes anticipated changes for non-EHBs, deductible leveraging, fees, and risk mitigation programs.

{5} Minor rate variances may occur due to differences in rounding methodology.

ADDENDUM I: STATE REQUIREMENTS

Mapping of each Actuarial Memorandum Requirement of the State of New York to its location in this submitted Actuarial Memorandum

Actuarial Memorandum Requirement	Location in this Submitted Actuarial Memorandum
(h) The process used for the determination of the Index Rate and premium rates for both on-	Addendum III - Development of Plan-Level Premium Rates by Census Tier
(1) Average PMPM Incurred Claims for the latest experience period.	
(2) Average AV Pricing Value determined for all inforce plans in effect during the latest experience period, based on member-months in the experience period for each inforce plan.	
(3) Average Induced Demand Adjustment factor determined based on member-months in the experience period for each inforce plan.	
(4) Assumptions as to average annual claim trend rates for all components, including inflation, utilization, leverage, and other factors.	
(5) Projection trend factor from midpoint of experience period to midpoint of applicability for First Quarter 2014 premium rates.	
(6) Projected Average PMPM Incurred Claims determined from (1) and (5) above.	
(7) Market-wide index rate adjustments as discussed in Section 6, not already reflected.	
(8) For all inforce plans combined, determine the "Index" PMPM Claim Rate. This step reflects the Projected PMPM Incurred Claims per (6) above with Market-Wide adjustments prescribed in HHS regulation per (7) above.	
(9) Determine the starting point PMPM Claim Rate for each Non-Grandfathered Plan (both On-Exchange and Off-Exchange) by multiplying the Index PMPM Claim Rate for all inforce plans combined per (8) above by the ratio of (A) to (B), as follows: (A) The AV Pricing Value for each Non-Grandfathered Plan, both On-Exchange and Off-Exchange, at each of the Metal Tier levels; (B) The Average AV Pricing Value per (2) above for all inforce plans.	
(10) Plan-Design Level Adjustments for the various differences in characteristics as described above.	
(11) Plan-Design Level Adjustments for Administrative Costs and Profit Margins per Exhibit 9.	
(12) Preliminary PMPM Premium Rate for each Non-Grandfathered Plan, as determined from items (10) and (11) above, e.g., (10) divided by 100% less (11).	
(13) Final (all regions combined) Premium Rates for all Non-Grandfathered Plans for Employees only, for Employees and Spouse, for Employees and Child(ren) and for Employees and Spouse and Child(ren), based on census factors prescribed by the Department.	
(14) Final Premium Rates for each Non-Grandfathered Plans for each applicable rating region based on the area factors by region as determined by the Company's' actuary, and as explained in the Actuarial Memorandum.	Rate Manual
(15) Final Premium rates for subsequent quarters in calendar year 2014.	

(i) Supporting details on the key assumptions and additional information to be included in actuarial memorandum:	See below.
(1) Assumptions on annual claim trend rates, including if available, information on experienced annualized claim trend rates on allowed charges;	Section 4: Credibility Manual Rate Development
(2) Justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic (aging) change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components that is not part of the Market-Wide Index Rate Adjustments;	Section 4: Credibility Manual Rate Development
(3) Assumptions on Administrative costs components, including (a) explanations for differences in expense components between the current Exhibit 9 for Non-Grandfathered plans and the Exhibit 2 submitted for inforce plans in the most recent/current Sections 3231(e)(1)/4308(c) Rate Adjustment submission, and (b) reconciliation with administrative costs information reported in latest financial statements; and	Section 7: Non-Benefit Expenses, Profit and Risk
(4) Assumptions on profit margins or contribution to surplus, including a discussion on Return on Equity.	Section 7: Non-Benefit Expenses, Profit and Risk
(5) Details as to adjustments to Actuarial Values determined based on HHS AV Calculator for inforce plans.	Section 11: Actuarial Value Metal Values
(6) SERFF Number of the associated QHP Template filing.	Not Applicable
(7) Details as to the restructuring of the various "composite" premium rates into separate premium rates for the various census cells, i.e. Employees only, Employees and Spouse, Employees and Child(ren) and Employees and Spouse and Child(ren), using the census factor tier factors prescribed by the Department.	Section 8: Average 2014 Rating Factors
(8) Details as to the determination of the premium rates by the standardized rating regions.	Section 8: Average 2014 Rating Factors
(9) Details as to adjustments to the premium rates for the impact of risk adjustments, including the results for the simulations performed by the Department and the support for the adjustments introduced.	Section 6: Risk Adjustment and Reinsurance
(10) Details and support on any other adjustments deemed necessary by the Company's actuary.	Section 4: Credibility Manual Rate Development
(11) If the source data for the determination of the premium rates for the Exchange plans is other than the actual claims experience under Non-Grandfathered/Grandfathered plans, indicate the source of this data (e.g., the publication, organization, or consultants), and the applicability of this source data.	Section 4: Credibility Manual Rate Development

Addendum II - Listing of Plans in the Risk Pool

Empire HealthChoice Assurance, Inc. Small Group

On or Off Exchange	HIOS Plan Name	Metal Tier	Metal AV Value	Cost Sharing Features			
				In Network Deductible	In Network Coins.	In Network OOP Max	Out of Network Coverage
Off Exchange	Empire Core Guided Access Plus w HSA gugb	Bronze	0.6021	\$3,500	20%	\$6,350	No
Off Exchange	Empire Core Guided Access Plus w HSA gwgb	Bronze	0.5885	\$4,500	30%	\$6,350	No
Off Exchange	Empire Essential Guided Access Plus gwoa	Silver	0.7003	\$1,500	35%	\$6,350	No
Off Exchange	Empire Essential Guided Access Plus w/Dental gwoa	Silver	0.7003	\$1,500	35%	\$6,350	No
Off Exchange	Empire Essential Guided Access Plus w HSA gbcb	Silver	0.6835	\$2,500	20%	\$4,500	No
Off Exchange	Empire Preferred Guided Access Plus w HSA gsqa	Gold	0.7836	\$1,250	10%	\$6,350	No
Off Exchange	Empire Healthy New York HMO ggza	Gold	0.7900	\$600	20%	\$4,000	No

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 1)

Empire HealthChoice Assurance, Inc. Small Group

1)	Average PMPM Incurred Claims	\$403.39
2)	Average AV Pricing Value of All Inforce Plans	1.2195
3)	Average Induced Demand Adjustment Factor for All Inforce Plans	1.1253
4)	Average Annual Trend Rate Components	
	a) Annual Trend Assumption	11.1%
	b) Number of Trend Months	27
5)	Projected Trend Factor: $[1 + (4)(a)] ^ [(4)(b) \div 12]$	1.2669
6)	Projected PMPM Incurred Claims: (1) x (5)	\$511.06
7)	Market-Wide Index Rate Adjustments {1}	
	a) Benefit Changes	0.9518
	b) Changes in Provider Network	0.9092
	c) Fee Schedule Changes	1.0000
	d) Utilization Management Changes	1.0000
	e) Age/Gender Normalization	1.0000
	f) Morbidity Changes	1.0062
	g) Area/Network Normalization	1.0004
	h) Federal Risk Adjustment Program Impact	0.9655
	i) Federal Transitional Reinsurance Program Recovery	1.0133
	j) Credibility Adjustment	1.0000
	k) Rx Rebates	0.9816
	l) Induced Demand from Cost Share Reductions	1.0000
	m) Grace Period	1.0000
	n) <u>Total Market-Wide Index Rate Adjustments</u>	<u>0.8365</u>
8)	"Index" PMPM Claim Rate: (6) x (7)(o)	\$427.52
9)	Starting PMPM Claim Rate for Each Non-Grandfathered Plan	Part 2
10)	Plan-Level Adjustments for Benefit Characteristics	Part 2
11)	Plan-Level Adjustments for Administrative Costs & Profit Margin	Part 2
12)	Preliminary PMPM Premium Rate for Each Non-Grandfathered Plan	Part 2
13)	Final Plan-Level Premium Rates by Census Tier	Part 2
14)	Final Plan-Level Premium Rates by Census Tier and Rating Region	Rate Manual
15)	Premium Rates for Subsequent Quarters in Calendar Year 2014	Rate Manual

NOTES:

{1} For descriptions of these adjustments, refer to the Actuarial Memorandum, "Credibility Manual Rate" section.

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 2)

Empire HealthChoice Assurance, Inc. Small Group

HIOS Plan Name	8) "Index" PMPM Claim Rate, from Page 1	9) Starting PMPM Claim Rate for Each Non-Grandfathered Plan				10) Plan-Level Adjustments for Benefit/Plan Characteristics		
		a) Initial Plan Pricing AV {1}	b) Adjusted Plan Pricing AV {2}	c) Average Experience Period Pricing AV	d) Starting PMPM Claim Rate: (8) x [(9)(b) ÷ (9)(c)]	a) Benefit Adjustment {3}	b) Order of Operations and Rounding Adjustment	c) PMPM Claim Rate After Adjustments: (9)(d) x (10)(a-b)
Empire Core Guided Access Plus w HSA gugb	\$427.52	0.7765	0.7948	1.2195	\$278.64	1.0388	0.9997	\$289.34
Empire Core Guided Access Plus w HSA gwgb	\$427.52	0.7290	0.7473	1.2195	\$262.00	1.0412	0.9994	\$272.64
Empire Essential Guided Access Plus gwoa	\$427.52	0.9176	0.9359	1.2195	\$328.10	1.0329	1.0002	\$338.98
Empire Essential Guided Access Plus w/Dental gwoa	\$427.52	0.9176	0.9359	1.2195	\$328.10	1.0799	1.0002	\$354.38
Empire Essential Guided Access Plus w HSA gbcb	\$427.52	0.9050	0.9233	1.2195	\$323.69	1.0333	1.0002	\$334.55

{1} The Initial Plan Pricing AVs are computed prior to the plan-level adjustments in (10) and (11) and are not normalized relative to the reference plan; therefore, the values in this column will not match the benefit plan factors in Exhibit J or the Plan Pricing AVs in URRT.

{2} The Adjusted Plan Pricing AVs include the cost of Pediatric Dental, Pediatric Vision and Gym Membership.

{3} Benefit Adjustments include the Covered Lives Assessment, Healthy New York Subsidy and benefits in addition to Essential Health Benefits.

{4} For the development of the conversion factor, refer to Exhibit M.

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 2)

Empire HealthChoice Assurance, Inc. Small Group

HIOS Plan Name	11) Plan-Level Adjustments for Administrative Costs and Profit Margins, as a % of Premium			12) Preliminary PMPM Premium Rate for Each Non-Grandfathered Plan: (10) ÷ [1 - (11)(c)]
	a) Administrative Costs, excluding Profits	b) Profit/Contribution to Surplus Margins	c) Total Administrative Expense Load: (11)(a) + (11)(b)	
Empire Core Guided Access Plus w HSA gugb	14.49%	3.00%	17.49%	\$350.66
Empire Core Guided Access Plus w HSA gwgb	14.49%	3.00%	17.49%	\$330.42
Empire Essential Guided Access Plus gwoa	14.49%	3.00%	17.49%	\$410.82
Empire Essential Guided Access Plus w/Dental gwoa	14.49%	3.00%	17.49%	\$429.48
Empire Essential Guided Access Plus w HSA gbcb	14.49%	3.00%	17.49%	\$405.45

{1} The Initial Plan Pricing AVs are computed prior to the plan-level adjustments in (10) and (11) and are not normalized relative to the reference plan; therefore, the values in this column will not match the benefit plan factors in Exhibit J or the Plan Pricing AVs in URRT.

{2} The Adjusted Plan Pricing AVs include the cost of Pediatric Dental, Pediatric Vision and Gym Membership.

{3} Benefit Adjustments include the Covered Lives Assessment, Healthy New York Subsidy and benefits in addition to Essential Health Benefits.

{4} For the development of the conversion factor, refer to Exhibit M.

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 2)

Empire HealthChoice Assurance, Inc. Small Group

HIOS Plan Name	13) Final Premium Rates (all regions combined)					
	a) Conversion Factor {4}	b) Single Premium Rate: (12) x (13)(a)	c) Individual: (13)(b) x 1.00	d) Husband/ Wife: (13)(b) x 2.00	e) Parent/ Child(ren): (13)(b) x 1.70	f) Family: (13)(b) x 2.85
Empire Core Guided Access Plus w HSA gugb	1.199	\$420.27	\$420.27	\$840.54	\$714.46	\$1,050.68
Empire Core Guided Access Plus w HSA gwgb	1.199	\$396.01	\$396.01	\$792.02	\$673.22	\$990.03
Empire Essential Guided Access Plus gwoa	1.199	\$492.37	\$492.37	\$984.74	\$837.03	\$1,230.93
Empire Essential Guided Access Plus w/Dental gwoa	1.199	\$514.73	\$514.73	\$1,029.46	\$875.04	\$1,286.83
Empire Essential Guided Access Plus w HSA gbcb	1.199	\$485.93	\$485.93	\$971.86	\$826.08	\$1,214.83

{1} The Initial Plan Pricing AVs are computed prior to the plan-level adjustments in (10) and (11) and are not normalized relative to the reference plan; therefore, the values in this column will not match the benefit plan factors in Exhibit J or the Plan Pricing AVs in URRT.

{2} The Adjusted Plan Pricing AVs include the cost of Pediatric Dental, Pediatric Vision and Gym Membership.

{3} Benefit Adjustments include the Covered Lives Assessment, Healthy New York Subsidy and benefits in addition to Essential Health Benefits.

{4} For the development of the conversion factor, refer to Exhibit M.

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Empire HealthChoice Assurance, Inc.
State:	New York
HIOS Issuer ID:	44113
Market:	Small Group
Effective Date:	January 1, 2014

- Company Contact Information

Primary Contact Name:	[REDACTED]
Primary Contact Telephone Number:	[REDACTED]
Primary Contact Email Address:	[REDACTED]

2. Scope and Purpose of the Filing

To the best of Empire's knowledge and current understanding, this filing complies with the most recent regulations and related guidance. Empire's intention is to fully comply with all applicable laws and guidance; however, the regulatory framework continues to change and evolve rapidly. To the extent relevant rules or guidance on the rules are updated or changed, amendments to this filing may be required.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA). The rates will be in-force for effective dates on or after January 1, 2014. 2014 rate changes will be implemented quarterly as discussed in more detail in Section 10: Index Rate. These rates will apply to plans offered Off-Exchange. This rate filing is not intended to be used for other purposes.

Policy Form Number(s):	NY_EPO_GA_012014
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3. Description of How the Base Rate Is Determined

The development of the Base Rate is detailed in Exhibit A - Base Rate Development. Further details on how the base rate is developed can be found in Section 4: Credibility Manual Rate Development, Section 6: Risk Adjustment and Reinsurance, Section 7: Non-Benefit Expenses, Profit and Risk, and Section 8: Average 2014 Rating Factors. A description of the methodology used to determine the base rate is as follows:

- Small Group manual rates are developed based on historical experience of Grandfathered and Non-Grandfathered business.
- The experience data is normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period based on expected distribution of membership.
- The projected claims cost is calculated by adjusting the normalized claims for the impact of benefit changes, population morbidity, trend factors, other cost of care impacts and other claim adjustments.
- The projection period is February 1, 2014 - January 31, 2015.
- Adjustments for risk adjustment and reinsurance are applied to the projected claims cost.
- Non-benefit expenses, profit, and risk are applied to the projected claims cost to determine the required projection period premium.
- The average rating factors in the projection period are applied to the projection period premium to determine the base rate.
- The base rate represents an average benefit plan and area for a single adult.

Premiums at the contract type level are determined by multiplying the base rate by the applicable factor for each of the allowable rating criteria: benefit plan, area and family composition. An example of this calculation is shown in Exhibit N - Sample Rate Calculation.

4. Credibility Manual Rate Development

Experience developed and projected herein is Empire's total Small Group Business, as well as all of Healthy New York, based on benefit expense. The rate development is shown in Exhibit A - Base Rate Development.

- Source and Appropriateness of Experience Data Used

The source data underlying the development of the manual rate consists of claims for all Grandfathered and Non-Grandfathered Small Group business, as well as all of Healthy New York, incurred during the period November 1, 2011 – October 31, 2012 and paid through December 31, 2012. Completion factors are then applied to reflect additional months of runout after December 31, 2012.

Other than completing the incurred claims, no further explicit adjustments are made to the experience data.

For more detail, see Exhibit B - Claims Experience for Manual Rate Development.

- **Adjustments Made to the Data**

The development of the projected claims is summarized in Exhibit A - Base Rate Development, items (1) - (10), and described in detail below.

The projected claims cost is calculated by multiplying the normalized claims cost by the impact of benefit changes, anticipated changes in population morbidity, and cost of care impacts. The adjustments are described below, and the factors are presented in Exhibit D - Projection Period Adjustments.

Changes in Demographics (Normalization)

The source data was normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period. The purpose of these factors is to adjust current experience to be reflective of expected claim experience in the projection period. See Section 13: Membership Projections for additional information on membership movement. The normalization factors and their aggregate impact on the underlying experience data are detailed in Exhibit C - Normalization Factors.

- **Age/Gender:** The assumed claims cost is applied by age and gender to the experience period distribution and the projection period distribution. Age/gender factors are developed from Milliman data.
- **Area/Network:** The area claims factors are developed based on an analysis of Small Group allowed claims, mapped to the prescribed 2014 rating areas using 5-digit zip code.
- **Benefit Plan:** The experience period claims are normalized to an average 2014 plan using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements. The adjustments for anticipated changes in utilization are in accordance with the DFS Instructions for the submission of 2014 premium rates, Section 5: "Induced Demand."

Changes in Benefits

Benefit changes include the following:

- **Preventive Rx (over the counter):** The claims are adjusted for 100% coverage of benefits for specific over the counter drugs obtained with a prescription from a physician.
- **Rx Adjustments:** The claims are adjusted for differences in the Rx formulary, mandatory mail order programs, and impacts for moving drugs into different tiers in the projection period relative to what is reflected in the base experience data.

Changes in the Morbidity of the Population Insured

The claims are adjusted to reflect shifts in health insurance coverage as a result of the provisions of the ACA. The market shifts, or population movements, affecting the morbidity of the Small Group market in the projection period include:

- Small Groups electing to drop coverage
- Small Group members electing to be uninsured
- Small Group members moving to Medicaid

The movement assumptions above are based on market research and assumptions on the employer opt-out and consumer uptake rates. The morbidity impacts of population movement are based on health status determined from internal risk score data.

Trend Factors

- The annual pricing trend used in the development of the rates includes the underlying cost of care claims trend (including anticipated changes in provider contracts), which has been normalized for persistent business, age/gender, and large claims, plus an estimate for leveraging, aging and a provision for adverse deviation. The claims are trended 27 months from the midpoint of the experience period, which is May 1, 2012, to the midpoint of the projection period, which is August 1, 2014.
- Empire's overall pricing trend is approximately 11.1% and consists of the following components:
 - ✦ Underlying Trend: Empire's Cost of Care Actuaries calculate the underlying trend data. This trend excludes aging, leveraging and selection adjustments, but includes the impact of new technology and cost of care initiatives. The underlying trend is roughly 7%.
 - ✦ Aging Adjustment: The aging adjustment is just under 3%.
 - ✦ Cost Sharing Leveraging Adjustment: The cost sharing leveraging adjustment is roughly 1%.

Other Claim Adjustments

The adjustments described below are presented in Exhibit E - Other Claim Adjustments.

- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.

- The cost of adding benefits for pediatric dental, pediatric vision and gym membership are included.
- Covered Lives Assessment: This indirect New York tax is a charge on all fully and self insured “covered lives”. The purpose of the Covered Lives Assessment is to raise funds for a variety of state programs and for the state Budget. The Assessment is included in claims costs for purposes of calculating the MLR.
- Healthy New York Subsidy: The projected Regulation 171 recovery for high cost claimants in the Healthy New York policy.
- Additional Non-EHBs: Clinical packages including programs such as Future Moms, Nurse Line and Healthy Lifestyles

- Capitation Payments

The underlying data includes capitation payments, which are combined with the base medical and pharmacy claims and projected at the same rate. No further adjustment is made to the capitation.

5. Credibility of Experience

The combination of both Grandfathered and Non-Grandfathered experience data most reasonably reflects Small Group claims experience under the future projection period. Actuarial judgment has been exercised to determine that rates will be developed giving full credibility to the data underlying the rates in Section 4: Credibility Manual Rate Development.

6. Risk Adjustment and Reinsurance

- Projected Risk Adjustment

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, Empire is assuming the risk for the plans in this filing are in accordance with the New York DFS risk adjustment simulation. This simulation shows that the risk adjuster payment for small group business in the HMO company is 14.3% of claims, while the risk adjuster payment for small group business in the Assurance company is -0.7% of claims. The weighted average of these percentages, based on total claims, yields a risk adjuster payment of 3.5% of claims, which is equivalent to \$13.37 PMPM in 2014, as shown in Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments.

- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The transitional reinsurance risk mitigation program collects funds from all insurance issuers and TPAs and redistributes them to high cost claimants in the Non-Grandfathered Individual market. The reinsurance contribution is equal to the national per capita reinsurance contribution rate as shown in Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments.

7. Non-Benefit Expenses, Profit and Risk

Non-Benefit expenses are detailed in Exhibit G - Non-Benefit Expenses and Profit & Risk.

- Administrative Expense

Administrative Expense contains both acquisition costs associated with the production of new business through non-broker distribution channels (direct, telesales, etc) as well as maintenance costs associated with ongoing costs for the administration of the business. Acquisition costs are projected using historical cost per member sold amounts applied to future sales estimates. Maintenance costs are assumed to be flat on a per member basis with savings from fixed cost leverage and the elimination of underwriting offset by new expenses for risk management, regulatory compliance and premium reconciliation and balancing.

- Quality Improvement Expense

The quality improvement expense represents Empire's dedication to providing the highest standard of customer care and consistently seeking to improve health care quality, outcomes and value in a cost efficient manner.

See Exhibit H - Quality Improvement/Cost Containment Programs for a description of these programs.

- Selling Expense

Selling Expense represents broker commissions and bonuses associated with the broker distribution channel using projected commission levels.

Empire recently filed a commission schedule for 2014 Small Group business.

- Taxes and Fees

- Patient-Centered Outcomes Research Institute (PCORI) Fee: The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund. For plan years ending before October 1, 2014, the fee is \$2 per member per year. Thereafter, for every plan year ending before October 1, 2019, the fee will increase by the percentage increase in National Healthcare Expenditures.
- Risk Adjustment Fee: The Risk Adjustment fee is a user fee to support the administration of the HHS operated Risk Adjustment program. The charge is \$1 per enrollee per year.
- ACA Insurer Fee: The health insurance industry will be assessed a permanent fee, based on market share of net premium, which is not tax deductible.
- Federal, state, and premium taxes are also included in the retention items.

- Profit

Profit is reflected on a post-tax basis as a percent that does not vary by product or plan.

- Changes in Exhibit 9 (formerly Exhibit 2) Expense Components

Differences in expense components between the current Exhibit 9 for Exchange plans and the Exhibit 2 submitted for inforce plans in the most recent/current Sections 3231(e)(1)/4308(c) Rate Adjustment applications are as follows:

- Projected administrative expenses, as a proportion of premium, are similar to those represented in the most recent 4308(c) and 3231(e)(1) filings. Notable differences are the increased commission, consistent with Empire's recently filed 2014 small group commission schedule; and an increase in taxes corresponding to new PPACA-related fees.

- Reconciliation with Financial Statements

Projected administrative expenses, as a proportion of premium, are similar to those represented in the 2012 financial statements. Again, differences would reflect the increased commission, consistent with Empire's recently filed 2014 small group commission schedule; and an increase in taxes corresponding to new PPACA-related fees.

8. Average 2014 Rating Factors

The required premium in the projection period is adjusted to reflect the average benefit plan, area and family composition rating factors to develop the rating period base rate. The average factors are shown in Exhibit I - Average 2014 Rating Factors and applied in line item 14 of Exhibit A - Base Rate Development.

- Benefit Plan Factors

Refer to Exhibit J - Non-Grandfathered Benefit Plan Factors.

- Area Factors

Refer to Exhibit K - Area Factors.

- Family Composition Factors

Refer to Exhibit L - Family Composition Factors.

9. Projected Loss Ratio

- Projected Federal MLR

The projected Federal MLR for the products in this filing is estimated in Exhibit O - Federal MLR Estimated Calculation. Please note that this calculation is purely an estimate and not meant to be a true measure for Federal or State MLR rebate purposes. The products in this filing represent only a subset of Empire's Small Group business. The MLR for Empire's entire book of Small Group business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to third party margins, three-year averaging, credibility, dual option, and deductible. Empire's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

10. Index Rate

- Projection Period Index Rate

The index rate, as defined in the Federal regulations, represents the average allowed claims PMPM of essential health benefits for Empire's total Small Group Non-Grandfathered Business. The first quarter projection period index rate was developed as shown in Exhibit P - Projected Index Rate Development by adjusting the projected incurred claims PMPM described in Section 4: Credibility Manual Rate Development of this memorandum. Projected trended index rates by quarter are also captured in Exhibit R - Quarterly Index and Base Rate. No benefits in excess of the essential health benefits are included in the projection period allowed claims and Exhibit R's projection period index rate. To calculate the required premium, the projection period index rate is adjusted only by the adjustments allowed per Market Reform and Payment Parameters Regulations. This development is presented in Exhibit Q - Development of Required Premium from Index Rate.

- Quarterly Index and Base Rate

Quarterly index and base rate changes will be implemented. Refer to Exhibit R - Quarterly Index and Base Rate.

11. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values included in Addendum II - Listing of Plans in the Risk Pool are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially-equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. Benefits for Plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

The Actuarial Value (AV) Metal Values for inforce plans are determined in the same fashion.

12. Actuarial Value Pricing Values

The Initial Plan Pricing AVs in Addendum III - Development of Plan-Level Premium Rates by Census Tier are developed using WellPoint's benefit relativity factor model, which is a modified Milliman model. The program allows induced utilization to be turned off and the DFS' recommended induced utilization amounts were used.

13. Membership Projections

Membership projections are developed using a population movement model and adjustments for sales expectations. This model projects the membership in the projection period by taking into account:

- Small Groups dropping coverage
- Small Group members opting out of coverage
- Small Group members to Medicaid as a result of expanded Medicaid eligibility

The plan distribution is based on assumed metal tier and network distributions.

Refer to Exhibit D - Projection Period Adjustments for the projected morbidity changes from population movement.

14. Pricing of Make Available Riders

Pricing methods for each of the required make-available riders are discussed below:

- Domestic Partner Rider

This rider is currently offered at no additional cost because it is assumed that the use of the appropriate contract type will cover the cost of this additional member. Empire intends to continue that practice of no additional charge going forward.

- Unlimited SNF Days Rider

The filed 2014 rates for Empire's current Small Group products apply between 0.05% and 0.14% for this additional SNF coverage. Empire proposes a rate of 0.07% to increase SNF days to be unlimited going forward, which is a weighted average of the range.

- Dependent Coverage through the Age of 29 Rider

The filed 2014 rates for Empire's current Small Group products apply between 3% and 10% on the contract types that have children for this coverage. A predominance of these plans charge approximately 4%, so going forward Empire proposes a charge of 4% of parent/child(ren) and family contracts for this coverage, which is a weighted average of the range.

- Opt-out of Contraceptives Rider

An enterprise study determined that contraceptive benefits are worth about 0.7% of Empire's average claim PMPM as developed for 2014. Empire proposes a rate of 0.7% to remove contraceptive coverage.

- Member Opt-in of Contraceptives Coverage

For a Small Group that opts out of contraceptive coverage, the members may opt to purchase this coverage directly from Empire. Empire proposes a single rate of \$3.20 (which is $0.7\% * 382.04 * 1.1985 = \text{opt-out rate} * \text{line 10 from Exhibit A} * \text{result of Exhibit M}$) to add back contraceptive coverage, consistent with the average amount removed from the group's rate.

15. State Actuarial Memorandum Requirements

For a mapping of each Actuarial Memorandum Requirement of the State of New York to its location in this submitted Actuarial Memorandum, please refer to Addendum I - State Requirements.

For a listing of all plans included in the risk pool, refer to Addendum II - Listing of Plans in the Risk Pool.

For a development of plan-level premium rates in the format requested by the DFS, refer to Addendum III - Development of Plan-Level Premium Rates by Census Tier.

16. Actuarial Certification

I, [REDACTED] am an actuary for Empire. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The filing is in compliance with all applicable laws and regulations of the State of New York;

(2) The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

- ✦ ASOP No. 5, Incurred Health and Disability Claims
- ✦ ASOP No. 8, Regulatory Filings for Health Plan Entities
- ✦ ASOP No. 12, Risk Classification
- ✦ ASOP No. 23, Data Quality
- ✦ ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ✦ ASOP No. 41, Actuarial Communications

(3) The expected loss ratio incorporated into the rate tables meets the minimum

(4) The benefits are reasonable in relation to the premiums charged; and

(5) The rates are not unfairly discriminatory.

[REDACTED]
[REDACTED]

May 13, 2013

Date

Exhibit A - Base Rate Development

Effective January 1, 2014

**Empire HealthChoice Assurance, Inc.
Small Group**

	<u>Paid Claims</u>	
1) Experience Period Cost PMPM	\$ 404.78	Exhibit B
2) <u>x Normalization Factor</u>	0.7957	Exhibit C
3) = Normalized Claims	\$ 322.08	= (1) x (2)
4) x Benefit Changes	0.9518	Exhibit D
5) x Morbidity Changes	1.0062	Exhibit D
6) x Medical Trend Factor	1.2669	Exhibit D
7) <u>x Other Cost of Care Impacts</u>	1.0000	Exhibit D
8) = Projected Claim Cost	\$ 390.78	= (3) x (4) x (5) x (6) x (7)
9) + Other Claim Impacts	(\$8.74)	Exhibit E
10) = Claims Projected to Projection Period	\$ 382.04	= (8) + (9)
11) + Risk Mitigation - Contributions and Payments	(\$8.27)	Exhibit F
12) <u>+ Selling Expense, Administration and Other Retention Items {1}</u>	\$79.21	Exhibit G
13) = Required Premium in Projection Period	\$ 452.98	= (10) + (11) + (12)
14) (a) x Average Contract Size Factor in Projection Period	1.7630	Exhibit H
(b) ÷ Average Rating Factors (Rating Tier/Area/Plan) in Projection Period	1.4710	Exhibit H
15) = Base Rate (Average Plan-Level)	\$ 542.90	= (13) x (14a) ÷ (14b)
16) Projected Loss Ratio (Conventional Basis)	82.5%	= [(10) + (11)] ÷ (13)

NOTES:

{1} Equivalent to PMPM expenses on Exhibit G + % of premium expenses on Exhibit G applied to Required Premium (Row 13 above).

Exhibit B - Claims Experience for Manual Rate Development

Empire HealthChoice Assurance, Inc.
Small Group

Incurred November 1, 2011 through October 31, 2012
Paid through December 31, 2012

Healthy New York and SG HMO In-Area Business:

PAID CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
\$ 718,221,511	\$ 166,352,891	\$ 14,960,832	\$ 52,990	\$ 733,182,343	\$ 166,405,881	\$ 4,400,705	\$ 903,988,929	2,233,257	\$ 404.78	

ALLOWED CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
\$ 904,805,783	\$ 211,479,742	\$ 18,420,701	\$ 66,206	\$ 923,226,484	\$ 211,545,948	\$ 4,400,705	\$ 1,139,173,137	2,233,257	\$ 510.09	

Exhibit C - Normalization Factors

Empire HealthChoice Assurance, Inc.
Small Group

Experience Period: November 1, 2011 through October 31, 2012

<u>Normalize to population expected in 2014</u>			
<i>Average claim factors based on future population as compared to experience period population:</i>			
	Average Claim Factors		Normalization
	Experience Period Population	Future Population	Factor
Age/Gender	1.1055	1.1055	1.0000
Area/Network	1.0011	0.9106	0.9096
Benefit Plan	1.2194	1.0668	0.8748
Total	1.3495	1.0739	0.7957

Exhibit D - Projection Period Adjustments

Empire HealthChoice Assurance, Inc.
Small Group

Impact of Changes Between Experience Period and Projection Period:

	<u>Adjustment Factor</u>
<u>Benefit changes</u>	
Preventive Rx (over the counter)	1.0005
Eliminate Pre-Ex	1.0000
<u>Rx Adjustments {1}</u>	<u>0.9513</u>
Total Benefit Changes	0.9518
<u>Morbidity changes</u>	
Total Morbidity Changes	1.0062
<u>Cost of care impacts</u>	
Annual Medical/Rx Trend Rate	11.09%
# Months of Projection	27
Trend Factor	1.2669

NOTES:

{1} Includes Rx formulary, mandatory mail order

Exhibit E - Other Claim Adjustments

Empire HealthChoice Assurance, Inc. Small Group

<i>Adjustments to projection period claims to reflect covered benefits not included in experience period data:</i>	
	<u>PMPM</u>
Rx Rebates	(\$7.20)
Pediatric Dental	\$3.62
Pediatric Vision	\$0.89
Gym Membership	\$0.99
Covered Lives Assessment	\$7.28
Healthy New York Subsidy	(\$18.04)
<u>Additional Non-EHBs {1}</u>	<u>\$3.72</u>
Total	(\$8.74)

{1} The 'Additional Non-EHBs' adjustment above reflects ONLY additional costs beyond those already captured in line Item 8 of Exhibit A. Line Item 8 of Exhibit A includes \$0.36 of embedded Non-EHB medical costs resulting from inclusion in the experience data and/or the normalization process.

Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments

Empire HealthChoice Assurance, Inc.
Small Group
Effective January 1, 2014

<u>Risk Adjustment:</u>			
Description	Transfers funds from lowest risk plans to highest risk plans		
Participants	Non-Grandfathered Individual and Small Group plans (inside and outside Exchange) are eligible		
PMPM	Net Transfer		
Federal Program	(\$13.37)		
	<u>Note:</u>		
	It is assumed the risk for the plans included in this rate filing is worse overall than other plans within this market.		
<u>Reinsurance:</u>			
Description	Provides funding to plans that enroll highest cost individuals		
Participants	All insurance issuers and TPAs contribute funds		
	Non-Grandfathered Individual plans (inside and outside Exchange) are eligible for payments		
PMPM	Contributions Made	Payments Received	
Federal Program	\$5.10	\$0.00	<i>Small Group Plans contribute funds but only Individual Plans are eligible to receive payments</i>
	<u>Source:</u>		
	HHS estimates a national per capita contribution rate of \$5.25 per month (\$63 per year) in benefit year 2014 (per Payment Parameter Rule).		
Grand Total of All Risk Mitigation Programs			(\$8.27)

NOTES:

\$5.10 = \$5.25 * (11 months/12months) + \$3.50 * (1 months/12 months)

\$5.25 = 2014 contribution

\$3.50 = 2015 contribution

Exhibit G - Non-Benefit Expenses and Profit & Risk

Empire HealthChoice Assurance, Inc. Small Group

	<u>PMPM</u>	<u>% Premium</u>
Administrative Costs	\$29.01	
Quality Improvement Expense	\$2.61	
Selling Expense	\$8.66	
ACA Related Fees:		
PCORI Fee	\$0.17	
Risk Adjustment User Fee	\$0.08	
ACA Insurer Fee		2.55%
Exchange User Fee		0.00%
Premium Tax		2.99%
Federal/State Taxes		1.05%
Profit (Post-Tax)		1.95%
Total	\$40.53	8.54%

Exhibit H - Quality Improvement/Cost Containment Programs

Empire HealthChoice Assurance, Inc. Small Group

Radiology and Cardiac	Prospective clinical appropriateness reviews for diagnostic imaging .
Specialty Pharmacy Program	Prospective clinical appropriateness reviews for specialty pharmaceuticals.
OptiNet	A web-based application supports collaboration and more informed decision-making by physicians and members when selecting diagnostic imaging facilities.
Specialty Care Shopper Program	A member-engagement program that aims to provide members with choices between high-cost and low-cost imaging facilities with equal or better quality by information sharing and proactive member call outs.
Sleep Program	A Sleep Medicine Management Program that conducts pre-service clinical appropriateness review.
Physical Therapy / Occupational Therapy (PT/OT) Management Program	The PT/OT Management program involves prior review of services with regard to established medical policy and clinical guidelines.
Discharge Planning	Discharge planning activities are comprehensive in nature and consist of organizing and transitioning care to lesser acute facilities, counseling patients on discharge instructions, care coordination, etc.
Care coordination	Nurses interface with the clinicians on a member's care team when members are admitted to the hospital.
Radiology Benefits Management Program	The Radiology Benefits Management program involves prior review of services with regard to established medical policy and clinical guidelines.
Pharmacy Prior Authorization	Prior authorization involves review of submitted pharmacy claims to ensure the intended use is FDA approved or recognized in a major compendia as being safe and effective in order to be a covered benefit.
Specialty Pharmacy Drug Reviews	Pre-certification process of specialty medications.
Care Management	Care management staff coordinates quality health care services and the optimization of benefits through a realistic, cost-effective, and timely care management plan.
ComplexCare	The ComplexCare program is a proactive, collaborative, member-centric model of care management in which chronic care management is emphasized for those members with chronic or multiple non-disease management types of condition(s) at future high risk.
ConditionCare (Disease Management) Program	A program to help maximize member health status, improve health outcomes, and control health care expenses associated with the following prevalent conditions: Asthma (pediatric and adult), Diabetes (pediatric and adult), Heart Failure (HF), Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD).
MyHealth Coach Program	MyHealth Coach nurses serve as a central point of contact for individuals who have questions about a health care related topic, condition or concern, a question about benefits, a concern about claim payment or language in an 'Explanation of Benefits' statement.
Chronic Kidney Disease	The Kidney Disease Management: Chronic Kidney Disease (late stage) and End Stage Renal Disease program is designed to Improve participant's quality of life and clinical outcomes, slowing the progression of the disease and controlling costs related to hospitalizations, emergency room admissions and significant complications.
Nurseline	24/7 NurseLine is staffed exclusively by Registered Nurses who assist consumers in choosing the most appropriate use of health care resources, applying self care, learning about specific medical conditions, treatment options and side effects associated with prescription drugs, and providing valuable lifestyle management and nutrition information.
Healthy Lifestyles	Lifestyle management/health & wellness program that includes web-based programs & tools, telephonic lifestyle coaching and access to a national network of fitness centers.
MyHealth Advantage (MHA)	MHA comprises quality-based communications to members, physicians, health care plans, and pharmacists (as needed) on topics such as best-practice therapeutic interventions in member medical care.
Health IT	IT expenses in support of the programs noted above which have been identified as executing Quality Improvement activities.
Chiropractic Benefit Management Program	The Chiropractic benefit Management program involves retrospective review of services with regard to established medical policy and clinical guidelines.
Gym Reimbursement Program	The Gym Reimbursement program involves partially reimbursing the Subscriber and the Subscriber's Covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities and which maintain equipment and programs that promote cardiovascular wellness.

Exhibit I - Average 2014 Rating Factors

Empire HealthChoice Assurance, Inc.
Small Group

Effective January 1, 2014

<i>Average 2014 rating factors for 2014 population:</i>	
	Average Rating Factor
Average Contract Size	1.7630
Contract Type	1.4710
Area	1.0000
Benefit Plan	1.0000
Total (Contract Type x Area x Benefit Plan) =	1.4710
Conversion Factor	1.1985

Exhibit J - Non-Grandfathered Benefit Plan Factors

Empire HealthChoice Assurance, Inc.

Small Group

Effective January 1, 2014

Off-Exchange Plans:		
<u>Metal Level</u>	<u>HIOS Standard Component Plan ID</u>	<u>Benefit Plan Factor</u>
Bronze	44113NY0380004	0.7740
	44113NY0380005	0.7294
	44113NY0380009	0.7740
	44113NY0380010	0.7294
Silver	44113NY0380002	0.9068
	44113NY0380003	0.9480
	44113NY0380001	0.8950
	44113NY0380007	0.9068
	44113NY0380008	0.9480
	44113NY0380006	0.8950
Gold	80519NY0200001	1.0751
	80519NY0080001	0.8987
	80519NY0200002	1.0751
	80519NY0080002	0.8987

Benefit Plan Factors above reflect plan by plan differences from the index rate for allowable adjustments as described in detail in the Market Reform and Payment Parameters Regulations and illustrated in Exhibit Q. The weighted average of these adjustments for the entire risk pool included in this rate filing is detailed in Exhibit I.

Exhibit K - Area Factors

Empire HealthChoice Assurance, Inc.
Small Group
Effective January 1, 2014

Rating Area Description	Narrow Rating Factor
Albany	0.9435
Long Island	0.9335
Mid-Hudson	1.1051
New York City	1.0332
Upstate	1.4043

NOTES:

{1} Network adjustments (e.g., discount differences) are included in the benefit plan factors as shown in Exhibit J.

Exhibit L - Family Composition Factors

Empire HealthChoice Assurance, Inc.

Small Group

Effective January 1, 2014

Contract Type	Composition Factor
Single	1.00
Single + Spouse	2.00
Single + Child(ren)	1.70
Single + Spouse + Child(ren)	2.85

Exhibit M - Development of Conversion Factor

Empire HealthChoice Assurance, Inc.

Small Group

Effective January 1, 2014

Contract Type	Projected Contract Distribution	a) Prescribed Premium Relativity	b) Average Contract Size	c) Conversion Factor: (a) ÷ (b)
Individual	65%	1.00	1.00	
Husband/Wife	14%	2.00	2.00	
Parent/Child(ren)	5%	1.70	2.90	
Family	16%	2.85	4.30	
All Contracts	100%	1.4710	1.7630	1.1985

Exhibit N - Sample Rate Calculation

Empire HealthChoice Assurance, Inc. Small Group

Group Name: Sample Group
Effective Date: 01/01/2014
On/Off Exchange: Off
Metal Level: Bronze
Plan ID: 44113NY0380004
Rating Area: Albany
Network: Narrow
Group Census:

Calculation of Monthly Premium:

Base Rate =	\$	542.90	Exhibit A
x Benefit Plan Factor		0.7740	Exhibit J
<u>x Area Factor</u>		<u>0.9435</u>	Exhibit K
Base Rate Adjusted for Plan/Area =	\$	396.46	

Final Monthly Premium PMPM:

<u>Contract Type</u>	<u>Family Composition Factor (Exhibit L)</u>	<u>Monthly Rate</u>
Single	1.00	\$ 396.46
Single + Spouse	2.00	\$ 792.92
Single + Child(ren)	1.70	\$ 673.98
Single + Spouse + Child(ren)	2.85	\$ 1,129.91

Exhibit O - Federal MLR Estimated Calculation

Empire HealthChoice Assurance, Inc. Small Group

Numerator:

Incurred Claims	\$382.04	Exhibit A
+ Quality Improvement Expense	\$2.61	Exhibit G
+ Risk Corridor Contributions	\$0.00	
+ Risk Adjustment Contributions	\$0.00	Exhibit F
- Reinsurance Receipts	\$0.00	Exhibit F
- Risk Corridor Receipts:	\$0.00	
<u>- Risk Adjustment Receipts:</u>	<u>\$13.37</u>	Exhibit F
= <i>Estimated Federal MLR Numerator</i>	\$371.28	

Denominator:

Premiums	\$452.98	Exhibit A
- Federal and State Taxes	\$4.76	Exhibit A (Premium) and Exhibit G (Taxes)
- Premium Taxes	\$13.54	Exhibit A (Premium) and Exhibit G (Taxes)
- Reinsurance Contributions	\$5.10	Exhibit F
<u>- Licensing and Regulatory Fees</u>	<u>\$11.80</u>	Exhibit A (Premium) and Exhibit G (Fees)
= <i>Estimated Federal MLR Denominator</i>	\$417.78	

Estimated Federal MLR

88.87%

NOTES:

The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

- 1) The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.
- 2) Not all numerator/denominator components are captured above (for example, third party vendors excess reimbursement, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).
- 3) Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.
- 4) Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule

Exhibit P - Projected Index Rate Development

Effective January 1, 2014

Empire HealthChoice Assurance, Inc.
Small Group

1) Projected Paid Claim Cost	\$	390.78	Exhibit A, Line Item 8
2) <u>- Non-EHBs Embedded in Line Item 1) Above</u>		<u>\$0.36</u>	Exhibit E (see footnote in Exhibit E)
3) = Projected Paid Claims, Excluding ALL Non-EHBs	\$	390.42	
4) + Rx Rebates		(\$7.20)	Exhibit E
5) <u>+ Additional EHBs {1}</u>		<u>\$5.50</u>	Exhibit E
6) = Projected Paid Claims Reflecting <i>only</i> EHBs	\$	388.72	
7) <u>÷ Paid to Allowed Ratio</u>		<u>0.7576</u>	
8) = Projected Allowed Claims Reflecting <i>only</i> EHBs		\$513.09	= Index Rate

NOTE:

{1} Pediatric Dental, Pediatric Vision and Gym

Exhibit Q - Development of Required Premium from Index Rate

Effective January 1, 2014

Empire HealthChoice Assurance, Inc. Small Group

	<u>Weighted Average for Risk Pool</u>	
1) Index Rate - Federal Definition	\$513.09	Exhibit P
2) <u>x Paid to Allowed Ratio</u>	<u>0.7576</u>	Exhibit P
3) = Projected Paid Claims Reflecting <i>only</i> EHBs	\$388.72	
<u>Allowable Index Rate Adjustments {1} {2}: </u>		
4) x Benefit Adjustments	1.0000	
5) + Non-EHBs	(\$6.68)	Exhibit E
6) x Catastrophic Adjustment	1.0000	
7) x Network Adjustment	1.0000	
8) + Risk Mitigation - Contributions and Payments	(\$8.27)	Exhibit F
9) + <u>Selling Expense, Administration and Other Retention Items</u>	<u>\$79.21</u>	Exhibit G (also see Exhibit A, Line item 12)
10) = Required Premium in Projection Period	\$452.98	Ties to Exhibit A, Line item 13

NOTES:

- {1} Allowable adjustments to the index rate as made above are in accordance with the Market Reform and Payment Parameters Regulations.
- {2} The above illustrates the allowable adjustments to the average single risk pool index rate as included in this rate filing. These adjustments may vary on a plan by plan basis and such variances are captured in the benefit plan factors as summarized in Exhibit J.
- {3} Plan-level rates are obtained by multiplying the base rate as shown in line item 15 of Exhibit A by the benefit plan factors illustrated in Exhibit J. Further allowable adjustments (area and family composition) are applied to arrive at final premium rates.

Exhibit R - Quarterly Index and Base Rate

Empire HealthChoice Assurance, Inc. Small Group

	Rates Effective:				
	1Q14	2Q14	3Q14	4Q14	Wtd Avg
Renewing Member Months	558,314	558,314	558,314	558,314	2,233,257
Quarterly Allowed Trend		2.43%	2.43%	2.43%	
Index Rate	\$513.09	\$ 525.56	\$ 538.33	\$ 551.41	\$ 532.10
Quarterly Paid Trend		2.80%	2.80%	2.80%	
Base Rate	542.9	\$ 558.10	\$ 573.73	\$ 589.79	

NOTES:

{1} The 1Q14 index rate was derived in Exhibit P.

{2} The 1Q14 index rate is assumed to increase with quarterly allowed trend as illustrated above.

{3} The 1Q14 base rate was derived in Exhibit A.

{4} The 1Q14 base rate is assumed to increase with quarterly paid trend as illustrated above. This trend rate differs from the index rate trend in that it includes anticipated changes for non-EHBs, deductible leveraging, fees, and risk mitigation programs.

{5} Minor rate variances may occur due to differences in rounding methodology.

ADDENDUM I: STATE REQUIREMENTS

Mapping of each Actuarial Memorandum Requirement of the State of New York to its location in this submitted Actuarial Memorandum

Actuarial Memorandum Requirement	Location in this Submitted Actuarial Memorandum
(h) The process used for the determination of the Index Rate and premium rates for both on-	Addendum III - Development of Plan-Level Premium Rates by Census Tier
(1) Average PMPM Incurred Claims for the latest experience period.	
(2) Average AV Pricing Value determined for all inforce plans in effect during the latest experience period, based on member-months in the experience period for each inforce plan.	
(3) Average Induced Demand Adjustment factor determined based on member-months in the experience period for each inforce plan.	
(4) Assumptions as to average annual claim trend rates for all components, including inflation, utilization, leverage, and other factors.	
(5) Projection trend factor from midpoint of experience period to midpoint of applicability for First Quarter 2014 premium rates.	
(6) Projected Average PMPM Incurred Claims determined from (1) and (5) above.	
(7) Market-wide index rate adjustments as discussed in Section 6, not already reflected.	
(8) For all inforce plans combined, determine the "Index" PMPM Claim Rate. This step reflects the Projected PMPM Incurred Claims per (6) above with Market-Wide adjustments prescribed in HHS regulation per (7) above.	
(9) Determine the starting point PMPM Claim Rate for each Non-Grandfathered Plan (both On-Exchange and Off-Exchange) by multiplying the Index PMPM Claim Rate for all inforce plans combined per (8) above by the ratio of (A) to (B), as follows: (A) The AV Pricing Value for each Non-Grandfathered Plan, both On-Exchange and Off-Exchange, at each of the Metal Tier levels; (B) The Average AV Pricing Value per (2) above for all inforce plans.	
(10) Plan-Design Level Adjustments for the various differences in characteristics as described above.	
(11) Plan-Design Level Adjustments for Administrative Costs and Profit Margins per Exhibit 9.	
(12) Preliminary PMPM Premium Rate for each Non-Grandfathered Plan, as determined from items (10) and (11) above, e.g., (10) divided by 100% less (11).	
(13) Final (all regions combined) Premium Rates for all Non-Grandfathered Plans for Employees only, for Employees and Spouse, for Employees and Child(ren) and for Employees and Spouse and Child(ren), based on census factors prescribed by the Department.	
(14) Final Premium Rates for each Non-Grandfathered Plans for each applicable rating region based on the area factors by region as determined by the Company's' actuary, and as explained in the Actuarial Memorandum.	Rate Manual
(15) Final Premium rates for subsequent quarters in calendar year 2014.	

(i) Supporting details on the key assumptions and additional information to be included in actuarial memorandum:	See below.
(1) Assumptions on annual claim trend rates, including if available, information on experienced annualized claim trend rates on allowed charges;	Section 4: Credibility Manual Rate Development
(2) Justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic (aging) change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components that is not part of the Market-Wide Index Rate Adjustments;	Section 4: Credibility Manual Rate Development
(3) Assumptions on Administrative costs components, including (a) explanations for differences in expense components between the current Exhibit 9 for Non-Grandfathered plans and the Exhibit 2 submitted for inforce plans in the most recent/current Sections 3231(e)(1)/4308(c) Rate Adjustment submission, and (b) reconciliation with administrative costs information reported in latest financial statements; and	Section 7: Non-Benefit Expenses, Profit and Risk
(4) Assumptions on profit margins or contribution to surplus, including a discussion on Return on Equity.	Section 7: Non-Benefit Expenses, Profit and Risk
(5) Details as to adjustments to Actuarial Values determined based on HHS AV Calculator for inforce plans.	Section 11: Actuarial Value Metal Values
(6) SERFF Number of the associated QHP Template filing.	Not Applicable
(7) Details as to the restructuring of the various "composite" premium rates into separate premium rates for the various census cells, i.e. Employees only, Employees and Spouse, Employees and Child(ren) and Employees and Spouse and Child(ren), using the census factor tier factors prescribed by the Department.	Section 8: Average 2014 Rating Factors
(8) Details as to the determination of the premium rates by the standardized rating regions.	Section 8: Average 2014 Rating Factors
(9) Details as to adjustments to the premium rates for the impact of risk adjustments, including the results for the simulations performed by the Department and the support for the adjustments introduced.	Section 6: Risk Adjustment and Reinsurance
(10) Details and support on any other adjustments deemed necessary by the Company's actuary.	Section 4: Credibility Manual Rate Development
(11) If the source data for the determination of the premium rates for the Exchange plans is other than the actual claims experience under Non-Grandfathered/Grandfathered plans, indicate the source of this data (e.g., the publication, organization, or consultants), and the applicability of this source data.	Section 4: Credibility Manual Rate Development

Addendum II - Listing of Plans in the Risk Pool

Empire HealthChoice Assurance, Inc. Small Group

On or Off Exchange	HIOS Plan Name	Metal Tier	Metal AV Value	Cost Sharing Features			
				In Network Deductible	In Network Coins.	In Network OOP Max	Out of Network Coverage
Off Exchange	Empire Core Guided Access Plus w HSA gugb	Bronze	0.6021	\$3,500	20%	\$6,350	No
Off Exchange	Empire Core Guided Access Plus w HSA gwgb	Bronze	0.5885	\$4,500	30%	\$6,350	No
Off Exchange	Empire Essential Guided Access Plus gwoa	Silver	0.7003	\$1,500	35%	\$6,350	No
Off Exchange	Empire Essential Guided Access Plus w/Dental gwoa	Silver	0.7003	\$1,500	35%	\$6,350	No
Off Exchange	Empire Essential Guided Access Plus w HSA gbcb	Silver	0.6835	\$2,500	20%	\$4,500	No
Off Exchange	Empire Preferred Guided Access Plus w HSA gsqa	Gold	0.7836	\$1,250	10%	\$6,350	No
Off Exchange	Empire Healthy New York HMO ggza	Gold	0.7900	\$600	20%	\$4,000	No

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 1)

Empire HealthChoice Assurance, Inc. Small Group

1)	Average PMPM Incurred Claims	\$403.39
2)	Average AV Pricing Value of All Inforce Plans	1.2195
3)	Average Induced Demand Adjustment Factor for All Inforce Plans	1.1253
4)	Average Annual Trend Rate Components	
	a) Annual Trend Assumption	11.1%
	b) Number of Trend Months	27
5)	Projected Trend Factor: $[1 + (4)(a)] ^ [(4)(b) \div 12]$	1.2669
6)	Projected PMPM Incurred Claims: (1) x (5)	\$511.06
7)	Market-Wide Index Rate Adjustments {1}	
	a) Benefit Changes	0.9518
	b) Changes in Provider Network	0.9092
	c) Fee Schedule Changes	1.0000
	d) Utilization Management Changes	1.0000
	e) Age/Gender Normalization	1.0000
	f) Morbidity Changes	1.0062
	g) Area/Network Normalization	1.0004
	h) Federal Risk Adjustment Program Impact	0.9655
	i) Federal Transitional Reinsurance Program Recovery	1.0133
	j) Credibility Adjustment	1.0000
	k) Rx Rebates	0.9816
	l) Induced Demand from Cost Share Reductions	1.0000
	m) Grace Period	1.0000
	n) <u>Total Market-Wide Index Rate Adjustments</u>	<u>0.8365</u>
8)	"Index" PMPM Claim Rate: (6) x (7)(o)	\$427.52
9)	Starting PMPM Claim Rate for Each Non-Grandfathered Plan	Part 2
10)	Plan-Level Adjustments for Benefit Characteristics	Part 2
11)	Plan-Level Adjustments for Administrative Costs & Profit Margin	Part 2
12)	Preliminary PMPM Premium Rate for Each Non-Grandfathered Plan	Part 2
13)	Final Plan-Level Premium Rates by Census Tier	Part 2
14)	Final Plan-Level Premium Rates by Census Tier and Rating Region	Rate Manual
15)	Premium Rates for Subsequent Quarters in Calendar Year 2014	Rate Manual

NOTES:

{1} For descriptions of these adjustments, refer to the Actuarial Memorandum, "Credibility Manual Rate" section.

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 2)

Empire HealthChoice Assurance, Inc. Small Group

HIOS Plan Name	8) "Index" PMPM Claim Rate, from Page 1	9) Starting PMPM Claim Rate for Each Non-Grandfathered Plan				10) Plan-Level Adjustments for Benefit/Plan Characteristics		
		a) Initial Plan Pricing AV {1}	b) Adjusted Plan Pricing AV {2}	c) Average Experience Period Pricing AV	d) Starting PMPM Claim Rate: (8) x [(9)(b) ÷ (9)(c)]	a) Benefit Adjustment {3}	b) Order of Operations and Rounding Adjustment	c) PMPM Claim Rate After Adjustments: (9)(d) x (10)(a-b)
Empire Core Guided Access Plus w HSA gugb	\$427.52	0.7765	0.7948	1.2195	\$278.64	1.0388	0.9997	\$289.34
Empire Core Guided Access Plus w HSA gwgb	\$427.52	0.7290	0.7473	1.2195	\$262.00	1.0412	0.9994	\$272.64
Empire Essential Guided Access Plus gwoa	\$427.52	0.9176	0.9359	1.2195	\$328.10	1.0329	1.0002	\$338.98
Empire Essential Guided Access Plus w/Dental gwoa	\$427.52	0.9176	0.9359	1.2195	\$328.10	1.0799	1.0002	\$354.38
Empire Essential Guided Access Plus w HSA gbcb	\$427.52	0.9050	0.9233	1.2195	\$323.69	1.0333	1.0002	\$334.55

{1} The Initial Plan Pricing AVs are computed prior to the plan-level adjustments in (10) and (11) and are not normalized relative to the reference plan; therefore, the values in this column will not match the benefit plan factors in Exhibit J or the Plan Pricing AVs in URRT.

{2} The Adjusted Plan Pricing AVs include the cost of Pediatric Dental, Pediatric Vision and Gym Membership.

{3} Benefit Adjustments include the Covered Lives Assessment, Healthy New York Subsidy and benefits in addition to Essential Health Benefits.

{4} For the development of the conversion factor, refer to Exhibit M.

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 2)

Empire HealthChoice Assurance, Inc. Small Group

HIOS Plan Name	11) Plan-Level Adjustments for Administrative Costs and Profit Margins, as a % of Premium			12) Preliminary PMPM Premium Rate for Each Non-Grandfathered Plan: (10) ÷ [1 - (11)(c)]
	a) Administrative Costs, excluding Profits	b) Profit/Contribution to Surplus Margins	c) Total Administrative Expense Load: (11)(a) + (11)(b)	
Empire Core Guided Access Plus w HSA gugb	14.49%	3.00%	17.49%	\$350.66
Empire Core Guided Access Plus w HSA gwgb	14.49%	3.00%	17.49%	\$330.42
Empire Essential Guided Access Plus gwoa	14.49%	3.00%	17.49%	\$410.82
Empire Essential Guided Access Plus w/Dental gwoa	14.49%	3.00%	17.49%	\$429.48
Empire Essential Guided Access Plus w HSA gbcb	14.49%	3.00%	17.49%	\$405.45

{1} The Initial Plan Pricing AVs are computed prior to the plan-level adjustments in (10) and (11) and are not normalized relative to the reference plan; therefore, the values in this column will not match the benefit plan factors in Exhibit J or the Plan Pricing AVs in URRT.

{2} The Adjusted Plan Pricing AVs include the cost of Pediatric Dental, Pediatric Vision and Gym Membership.

{3} Benefit Adjustments include the Covered Lives Assessment, Healthy New York Subsidy and benefits in addition to Essential Health Benefits.

{4} For the development of the conversion factor, refer to Exhibit M.

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 2)

Empire HealthChoice Assurance, Inc. Small Group

HIOS Plan Name	13) Final Premium Rates (all regions combined)					
	a) Conversion Factor {4}	b) Single Premium Rate: (12) x (13)(a)	c) Individual: (13)(b) x 1.00	d) Husband/ Wife: (13)(b) x 2.00	e) Parent/ Child(ren): (13)(b) x 1.70	f) Family: (13)(b) x 2.85
Empire Core Guided Access Plus w HSA gugb	1.199	\$420.27	\$420.27	\$840.54	\$714.46	\$1,050.68
Empire Core Guided Access Plus w HSA gwgb	1.199	\$396.01	\$396.01	\$792.02	\$673.22	\$990.03
Empire Essential Guided Access Plus gwoa	1.199	\$492.37	\$492.37	\$984.74	\$837.03	\$1,230.93
Empire Essential Guided Access Plus w/Dental gwoa	1.199	\$514.73	\$514.73	\$1,029.46	\$875.04	\$1,286.83
Empire Essential Guided Access Plus w HSA gbcb	1.199	\$485.93	\$485.93	\$971.86	\$826.08	\$1,214.83

{1} The Initial Plan Pricing AVs are computed prior to the plan-level adjustments in (10) and (11) and are not normalized relative to the reference plan; therefore, the values in this column will not match the benefit plan factors in Exhibit J or the Plan Pricing AVs in URRT.

{2} The Adjusted Plan Pricing AVs include the cost of Pediatric Dental, Pediatric Vision and Gym Membership.

{3} Benefit Adjustments include the Covered Lives Assessment, Healthy New York Subsidy and benefits in addition to Essential Health Benefits.

{4} For the development of the conversion factor, refer to Exhibit M.

Notes

For the Bronze plans there are 2 setups: one tab called "Plan Name – MH 0%" and one tab called "Plan Name".

We weighted the "Plan Name – MH 0%" AV 90% and the "Plan Name" AV 10% to achieve the final AV. 0% cost share) and OP facility (at X% cost share) assuming a 90%/10% distribution of OP office visits to OP facility (where X% represents the plan coinsurance).

For the non-HSA Silver plan, there are 2 setups: one that we are calling Coinsurance method and the other Copay method.

We weighted the Coinsurance AV 90% and the Copay AV 10% to achieve the final AV.

This was because of the product design to include first 3 OV combined for PCP/SPC, PT/OT/ST, Chiro, MH/SA at a copay and remainder at deductible coinsurance.

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

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$2,500.00
Coinsurance (% , Insurer's Cost Share)		80.00%
OOP Maximum (\$)		\$4,500.00
OOP Maximum if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
		\$500.00
		80.00%
		\$15,000.00

[Click Here for Important Instructions](#)

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

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages: Calculation underway.
 Actuarial Value: 68.4%
 Metal Tier: Silver
 \$3,517.94
 \$5,146.76

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$500.00	
Coinsurance (% , Insurer's Cost Share)	65.00%	100.00%	
OOP Maximum (\$)	\$6,350.00		
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$4,000.00	\$500.00	
Coinsurance (% , Insurer's Cost Share)	80.00%	100.00%	
OOP Maximum (\$)	\$6,350.00		
OOP Maximum if Separate (\$)			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input checked="" type="checkbox"/>	67%	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	49%		<input type="checkbox"/>	<input type="checkbox"/>		\$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preventive Well Baby Visits and Care	<input type="checkbox"/>	<input type="checkbox"/>	100%		<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	67%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	78%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$35.00
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$70.00
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	75%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum:	\$500
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input checked="" type="checkbox"/>	
# Copays (1-10):	3

Output

Status/Error Messages: Calculation underway.
 Actuarial Value: 70.5%
 Metal Tier: Silver
 \$3,630.28
 \$5,146.76

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$500.00	
Coinsurance (% , Insurer's Cost Share)	65.00%	100.00%	
OOP Maximum (\$)	\$6,350.00		
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$4,000.00	\$500.00	
Coinsurance (% , Insurer's Cost Share)	80.00%	100.00%	
OOP Maximum (\$)	\$6,350.00		
OOP Maximum if Separate (\$)			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input checked="" type="checkbox"/>	67%	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	49%		<input type="checkbox"/>	<input type="checkbox"/>		\$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Non-Preventive Well Baby Visits and Care	<input type="checkbox"/>	<input type="checkbox"/>	100%		<input type="checkbox"/>	<input type="checkbox"/>		\$50.00
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	67%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	78%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$35.00
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$70.00
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	75%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	Specialty Rx Coinsurance Maximum: \$500
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	# Days (1-10):
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	# Visits (1-10):
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input checked="" type="checkbox"/>	# Copays (1-10): 3

Output

Status/Error Messages: Calculation underway.
 Actuarial Value: 70.0%
 Metal Tier: Silver
 \$3,604.52
 \$5,146.76

User Inputs for Plan Parameters

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

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

- Deductible (\$) _____
- Coinsurance (% , Insurer's Cost Share) _____
- OOP Maximum (\$) _____
- OOP Maximum if Separate (\$) _____

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		\$3,500.00
		80.00%
		\$6,350.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
		\$500.00
		80.00%
		\$15,000.00

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Non-Preventive Well Baby Visits and Care	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input type="checkbox"/>	<input type="checkbox"/>	80%	
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	61%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$90.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	75%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages: Calculation underway.
 Actuarial Value: 60.1%
 Metal Tier: Bronze
 \$2,988.88
 \$4,976.71

User Inputs for Plan Parameters

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

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

- Deductible (\$) _____
- Coinsurance (% , Insurer's Cost Share) _____
- OOP Maximum (\$) _____
- OOP Maximum if Separate (\$) _____

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		\$3,500.00
		80.00%
		\$6,350.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
		\$5,500.00
		100.00%
		\$5,500.00

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98%	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preventive Well Baby Visits and Care	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	93%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	61%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$90.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	75%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages: Calculation underway.
 Actuarial Value: 60.2%
 Metal Tier: Bronze
 \$2,997.26
 \$4,976.71

User Inputs for Plan Parameters

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

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

- Deductible (\$) _____
- Coinsurance (% , Insurer's Cost Share) _____
- OOP Maximum (\$) _____
- OOP Maximum if Separate (\$) _____

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		\$4,500.00
		70.00%
		\$6,350.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
		\$500.00
		80.00%
		\$15,000.00

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Non-Preventive Well Baby Visits and Care	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>	80%	
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	44%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$90.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages: Calculation underway.
 Actuarial Value: 58.7%
 Metal Tier: Bronze
 \$2,923.56
 \$4,976.71

User Inputs for Plan Parameters

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

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

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$4,500.00
Coinsurance (% , Insurer's Cost Share)		70.00%
OOP Maximum (\$)		\$6,350.00
OOP Maximum if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$5,500.00
Coinsurance (% , Insurer's Cost Share)		100.00%
OOP Maximum (\$)		\$5,500.00
OOP Maximum if Separate (\$)		

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98%	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preventive Well Baby Visits and Care	<input type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	93%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	44%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$90.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages: Calculation underway.
 Actuarial Value: 58.9%
 Metal Tier: Bronze
 \$2,929.21
 \$4,976.71

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A.	Insurer Information: <u>Empire HealthChoice Assurance, Inc.</u> <small>Company submitting the rate adjustment request</small>	<u>A&H - 42</u> <small>Company Type</small>	<u>For Profit</u> <small>Org. Type</small>	<u>55093</u> <small>Company NAIC Code</small>
1 Liberty Plaza, Area NY0A14-0008, New York, NY 10006 <small>Company mailing address</small>				
B.	Contact Person: ██████████ <u>Actuarial Director</u> <small>Rate filing contact person name, title</small>	██████████ <small>Contact phone number</small>	██ <small>Contact Email address</small>	
C.	Actuarial Contact (If different from above): <u>Same as above</u> <small>Actuary name, title</small>	_____ <small>Actuary phone number</small>	_____ <small>Actuary Email address</small>	
D.	New Rate Information (See Note #1): <u>January 1, 2014 - December 31, 2014</u> <small>New rate applicability period</small>	<u>01/01/2014</u> <small>New rate effective date</small>	<u>AWLP-129023432</u> <small>SERFF Tracking Number</small>	
E.	Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):			
Small Group				

	Response
F. Provide responses for the following questions:	
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).	No
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, all required exhibits have been submitted.
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefilling.	No

Notes:

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

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:	Empire HealthChoice Assurance, Inc. <small>Company submitting the rate adjustment request</small>	A&H - 42 <small>Company Type</small>	For Profit <small>Org. Type</small>	55093 <small>Company NAIC Code</small>
	1 Liberty Plaza, Area NY0A14-0008, New York, NY 10006 <small>Company mailing address</small>			
B. Contact Person:	[REDACTED] <small>Rate filing contact person name, title</small>	[REDACTED] <small>Contact phone number</small>	[REDACTED] <small>Contact Email address</small>	
C. Actuarial Contact (If different from above):	Same as above <small>Actuary name, title</small>	 <small>Actuary phone number</small>	 <small>Actuary Email address</small>	
D. New Rate Information (See Note #1):	January 1, 2014 - December 31, 2014 <small>New rate applicability period</small>	01/01/2014 <small>New rate effective date</small>	AWLP-129023432 <small>SERFF Tracking Number</small>	

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

	Response
F. Provide responses for the following questions:	
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).	No
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, all required exhibits have been submitted.
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefilling.	No

Notes:

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

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

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

Company Name: Empire HealthChoice Assurance Inc.
 NAIC Code: 55093
 SERFF Number: AWLP-129023432
 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.
- B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG.
- C. In Column 4, market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (SG). Use the drop down list to enter the market segment.
- D. Product type is HMO, HMO based POS, POS-00N, EPO, PPO, Comprehensive Major Medical, Non-HMO. 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 it). 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 in comments).
- 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	
0407 with rider: R- EPO SG INN	Small Group Prism EPO Value EPO	Prism EPO Value EPO	SG EPO 1 SG EPO 2	1/1/2014 1/1/2014	SG SG	EPO EPO	Yes Yes	Closed Closed	2,366 405	20,960 5,017	XX XX
CR-GR-PPO	Small Group Empire Deluxe PPO	Deluxe PPO	SG PPO	1/1/2014	SG	PPO	Yes	Closed	N/A	N/A	XX
CR-GR-	Small Group Empire	Empire PPO /	SG PPO	1/1/2014	SG	PPO	Yes	Open	683	4,261	XX
CDHP-Grp.	CDHP	Empire Total	SG CDHP	1/1/2014	SG	Consumer	Yes	Closed	599	7,040	XX
R-EPO-Blue	Blue Essential EPO	Empire	SG EPO 2	1/1/2014	SG	EPO	Yes	Open	351	2,660	XX

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

T FILING

ool.
 mn 2. Skip a row between the different rating pools.
 r SG HMO Upstate if rating pools vary by rating region.
 ip (LG), Individual Health NY (HNY-IND), Small Group Healthy NY (HNY

based POS, Consumer Health Plans and Base+Supplemental.

fer to this product/policy form when communicating with the Department).

used in the actuarial memorandum).

			Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	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) (\$)	
0407 with rider: R- EPO SG INN	Small Group Prism EPO Value EPO	Prism EPO Value EPO	11/01/11 11/01/11	10/31/12 10/31/12	803,847 187,426	365,105,088 73,551,687	N/A 82,246,002	376,657,186 66,385,536	327,853,149 61,617,806	0 0	3,381,444 856,052	40,300,987 8,118,774	XX XX
CR-GR-PPO	Small Group Empire Deluxe PPO	Deluxe PPO	11/01/11	10/31/12	844	732,344	N/A	2,422,119	744,320	0	(11,350)	80,837	XX
CR-GR-	Small Group Empire	Empire PPO /	11/01/11	10/31/12	79,642	61,409,119	62,404,123	54,141,472	49,976,948	0	(147,057)	6,778,454	XX
CDHP-Grp.	CDHP	Empire Total	11/01/11	10/31/12	236,579	70,544,354	80,308,676	85,171,252	74,637,874	0	8,298	7,786,819	XX
R-EPO-Blue	Blue Essential EPO	Empire	11/01/11	10/31/12	66,111	24,110,738	26,960,793	6,331,565	19,794,672	0	135,609	2,661,389	XX

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

			First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	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) (\$)	
0407 with rider: R- EPO SG INN	Small Group Prism EPO Value EPO	Prism EPO Value EPO	11/01/10	10/31/11	1,685,920	701,704,567	N/A	622,895,896	622,895,896	0	24,405,446	81,657,071	XX
	Small Group Empire Deluxe PPO	Deluxe PPO	11/01/10	10/31/11	55,451	48,711,371	N/A	39,480,170	39,480,170	0	(892,207)	5,668,522	XX
CR-GR-	Small Group Empire	Empire PPO /	11/01/10	10/31/11	64,228	49,044,185	52,222,592	32,517,150	32,517,150	0	(486,113)	5,707,252	XX
CDHP-Grp.	CDHP	Empire Total	11/01/10	10/31/11	353,476	98,460,735	125,985,539	76,987,680	76,987,680	0	55,229	11,457,835	XX
R-EPO-Blue	Blue Essential EPO	Empire	11/01/10	10/31/11	46,137	16,752,839	20,531,783	3,202,728	3,202,728	0	374,020	1,949,521	XX

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

			Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)									
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	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) (\$)
0407 with rider: R- EPO SG INN	Small Group Prism EPO Value EPO	Prism EPO Value EPO	11/01/09 11/01/09	10/31/10 10/31/10	1,634,935 81,818	624,427,494 27,438,122	N/A 27,438,122	546,834,233 19,606,213	544,522,222 21,348,769	0 0	29,261,284 812,105	72,945,247 3,205,305
CR-GR-PPO	Small Group Empire Deluxe PPO	Deluxe PPO	11/01/09	10/31/10	112,650	93,664,554	N/A	69,256,910	67,026,359	0	-2,251,281	10,941,837
CR-GR-	Small Group Empire	Empire PPO /	11/01/09	10/31/10	0	0	0	0	5,958	0	0	0
CDHP-Grp.	CDHP	Empire Total	11/01/09	10/31/10	85,508	22,437,994	30,671,117	15,529,649	16,917,443	0	121,813	2,621,193
R-EPO-Blue	Blue Essential EPO	Empire	11/01/09	10/31/10	0	1,945	2,697	0	0	0	0	227

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Empire HealthChoice Assurance, Inc.

NAIC Code: 55093

SERFF Number: AWLP-129023432

Market Segment: Small Group

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

Line #	General	EPO QHP Off Exchange	EPO QHP Off Exchange	EPO QHP Off Exchange	EPO QHP Off Exchange	EPO QHP Off Exchange			
1	Product*								
2	Product ID*	44113NY038	44113NY038	44113NY038	44113NY038	44113NY038	44113NY038	44113NY038	44113NY038
3	Metal Level (or catastrophic)*	Bronze	Bronze	Bronze	Bronze	Silver	Silver	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.6021	0.5885	0.6021	0.5885	0.7003	0.7003	0.6835	0.7003
5	AV Pricing Value (total, risk pool experience based)*	0.8536	0.8043	0.8536	0.8043	1.0000	1.0454	0.9869	1.0000
6	Plan Type*	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
7	Plan Name*	Empire Core Guided Access Plus w HSA gugb	Empire Core Guided Access Plus w HSA gwgb	Empire Core Guided Access Plus w HSA gugb	Empire Core Guided Access Plus w HSA gwgb	Empire Essential Guided Access Plus gwoa	Empire Essential Guided Access Plus w/Dental gwoa	Empire Essential Guided Access Plus w HSA gbcb	Empire Essential Guided Access Plus gwoa
8	Plan ID*	44113NY0380004	44113NY0380005	44113NY0380009	44113NY0380010	44113NY0380002	44113NY0380003	44113NY0380001	44113NY0380007
9	Exchange Plan?*	Off Exchange	Off Exchange	Off Exchange	Off Exchange	Off Exchange	Off Exchange	Off Exchange	Off Exchange

* 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	900,877,904							
10B	Member-Months for Latest Experience Period	2,233,257							
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	403.39							
11	Average Pricing Actuarial Value reflected in experience period	1.219							
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	330.79							

Exhibit 8 - Index Rate/Plan Design Level Adjustme

Company Name: Empire HealthChoice Assuranc

NAIC Code: 55093

SERFF Number: AWLP-129023432

Market Segment: Small Group

Line #	General	EPO QHP Off Exchange	EPO QHP Off Exchange
1	Product*		
2	Product ID*	44113NY038	44113NY038
3	Metal Level (or catastrophic)*	Silver	Silver
4	AV Metal Value (HHS Calculator)*	0.7003	0.6835
5	AV Pricing Value (total, risk pool experience based)*	1.0454	0.9869
6	Plan Type*	EPO	EPO
7	Plan Name*	Empire Essential Guided Access Plus w/Dental gwoa	Empire Essential Guided Access Plus w HSA gcbcb
8	Plan ID*	44113NY0380008	44113NY0380006
9	Exchange Plan?*	Off Exchange	Off Exchange

* 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		
10B	Member-Months for Latest Experience Period		
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)		
11	Average Pricing Actuarial Value reflected in experience period		
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	330.79	330.79

Market Wide Adjustments to the AV

Adjusted Experience Period Index Rate

13	Impact of adjusting experience period data to EHB benefit level	0.952							
14	Market wide adjustment for changes in provider network **	0.909							
15	Market wide adjustment for fee schedule changes **	1.000							
16	Market wide adjustment for utilization management changes **	1.000							
17	Impact on risk pool of changes in expected covered membership risk characteristics **	1.006							
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 ** by the standard rating regions	1.000							
20	Federal Non-Resident Reinsurance Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	0.965							
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.013							
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)	1.267							
24	Other 1 (Rx Rebates)	0.982							
25	Other 2 (specify)	1.000							
26	Other 3 (specify)	1.000							
27	Impact of Market Wide Adjustments (product L13 through L26)	1.060							

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.777	0.729	0.777	0.729	0.891	0.891	0.879	0.891
29	Pricing actuarial value (only the induced demand factor) #	1.000	1.000	1.000	1.000	1.030	1.030	1.030	1.030
30	Impact of provider network characteristics ###	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ###	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Market Wide Adjustments to the AV

Adjusted Experience Period Index Rate

13	Impact of adjusting experience period data to EHB benefit level		
14	Market wide adjustment for changes in provider network **		
15	Market wide adjustment for fee schedule changes **		
16	Market wide adjustment for utilization management changes **		
17	Impact on risk pool of changes in expected covered membership risk characteristics **		
18	Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]		
19	Adjustment for changes in distribution of risk pool membership by rating regions **		
20	Adjustment for changes in distribution of risk pool membership by the standard rating regions (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)		
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)		
22	Impact of adjustments due to experience period claim data not being sufficiently credible		
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)		
24	Other 1 (Rx Rebates)		
25	Other 2 (specify)		
26	Other 3 (specify)		
27	Impact of Market Wide Adjustments (product L13 through L26)	1.060	1.060

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.891	0.879
29	Pricing actuarial value (only the induced demand factor) #	1.030	1.030
30	Impact of provider network characteristics ##	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000

Exhibit 8									
32	Impact of utilization management practices ##	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)	1.013	1.014	1.013	1.014	1.011	1.057	1.011	1.011
34	Administrative costs (excluding Exchange user fees and profits)	1.176	1.176	1.176	1.176	1.176	1.176	1.176	1.176
35	Profit/Contribution to surplus margins	1.031	1.031	1.031	1.031	1.031	1.031	1.031	1.031
36	Impact of eligibility categories (catastrophic plans only)	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
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Other 1 (Pediatric Dental, Pediatric Vision and Gym Membership)	1.024	1.025	1.024	1.025	1.020	1.020	1.020	1.020
40	Other 2 (Covered Lives Assessment and Rounding Adjustment)	1.025	1.027	1.025	1.027	1.022	1.022	1.022	1.022
41	Impact of Plan Level Adjustments (product L28 through L40)	1.000	0.943	1.000	0.943	1.172	1.225	1.157	1.172

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

Beyond what is reflected in Market Wide adjustments

42	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)	350.66	330.42	350.66	330.42	410.82	429.48	405.45	410.82
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Exhibit 8			
32	Impact of utilization management practices ##	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.057	1.011
34	Administrative costs (excluding Exchange user fees and profits)	1.176	1.176
35	Profit/Contribution to surplus margins	1.031	1.031
36	Impact of eligibility categories (catastrophic plans only)	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000
39	Other 1 (Pediatric Dental, Pediatric Vision and Gym Membership)	1.020	1.020
40	Other 2 (Covered Lives Assessment and Rounding Adjustment)	1.022	1.022
41	Impact of Plan Level Adjustments (product L28 through L40)	1.225	1.157

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

Beyond what is reflected in Market Wide adjustments

42	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)	429.48	405.45
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EXHIBIT 9 - SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN AND INCLUDED IN CURRENT RATE APPLICATION

Company Name: Empire HealthChoice Assurance, Inc.
 NAIC Code: 55093
 SERFF Number: AWLP-129023432
 Market Segment: Small Group

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	4.1 Period assumed - beginning date (MM/DD/YY)	4.2 Period assumed - ending date (MM/DD/YY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)
Bronze	Off Exchange	Empire Core Guided Access Plus w HSA gugb	02/01/14	01/31/15	11.09%	0.99%	0.58%	1.91%	2.00%	2.61%	6.40%	14.49%	1.95%	0.00%	0.00%
Bronze	Off Exchange	Empire Core Guided Access Plus w HSA gwgb	02/01/14	01/31/15	11.09%	0.99%	0.58%	1.91%	2.00%	2.61%	6.40%	14.49%	1.95%	0.00%	0.00%
Silver	Off Exchange	Empire Essential Guided Access Plus gwoa	02/01/14	01/31/15	11.09%	0.99%	0.58%	1.91%	2.00%	2.61%	6.40%	14.49%	1.95%	0.00%	0.00%
Silver	Off Exchange	Empire Essential Guided Access Plus w/Dental gwoa	02/01/14	01/31/15	11.09%	0.99%	0.58%	1.91%	2.00%	2.61%	6.40%	14.49%	1.95%	0.00%	0.00%
Silver	Off Exchange	Empire Essential Guided Access Plus w HSA gbc b	02/01/14	01/31/15	11.09%	0.99%	0.58%	1.91%	2.00%	2.61%	6.40%	14.49%	1.95%	0.00%	0.00%

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	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 \$mpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	12.3 Commissions and broker fees - as \$mpm	12.4 Premium Taxes - as \$mpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm	12.6 Other administrative expenses - as \$mpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as \$mpm	14. State income tax component - as \$mpm
Bronze	Off Exchange	Empire Core Guided Access Plus w HSA gugb	1.05%	35.00%	0.00%	17.49%	3.47	2.02	6.70	7.01	9.14	22.46	50.80	6.84	0.00
Bronze	Off Exchange	Empire Core Guided Access Plus w HSA gwgb	1.05%	35.00%	0.00%	17.49%	3.27	1.90	6.32	6.61	8.61	21.16	47.87	6.44	0.00
Silver	Off Exchange	Empire Essential Guided Access Plus gwoa	1.05%	35.00%	0.00%	17.49%	4.07	2.37	7.85	8.22	10.70	26.31	59.51	8.01	0.00
Silver	Off Exchange	Empire Essential Guided Access Plus w/Dental gwoa	1.05%	35.00%	0.00%	17.49%	4.25	2.47	8.21	8.59	11.19	27.50	62.22	8.37	0.00
Silver	Off Exchange	Empire Essential Guided Access Plus w HSA gbcg	1.05%	35.00%	0.00%	17.49%	4.01	2.34	7.75	8.11	10.56	25.96	58.74	7.91	0.00

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	15. Federal income tax component - as \$ppm	16. Reduction for assumed net investment income - as \$ppm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Bronze	Off Exchange	Empire Core Guided Access Plus w HSA gugb	3.68	0.00	61.32
Bronze	Off Exchange	Empire Core Guided Access Plus w HSA gwgb	3.47	0.00	57.78
Silver	Off Exchange	Empire Essential Guided Access Plus gwoa	4.31	0.00	71.84
Silver	Off Exchange	Empire Essential Guided Access Plus w/Dental gwoa	4.51	0.00	75.10
Silver	Off Exchange	Empire Essential Guided Access Plus w HSA gbcb	4.26	0.00	70.90

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A.	Insurer Information: <u>Empire HealthChoice Assurance, Inc.</u> <small>Company submitting the rate adjustment request</small>	<u>A&H - 42</u> <small>Company Type</small>	<u>For Profit</u> <small>Org. Type</small>	<u>55093</u> <small>Company NAIC Code</small>
<u>1 Liberty Plaza, Area NY0A14-0008, New York, NY 10006</u> <small>Company mailing address</small>				
B.	Contact Person: <div style="background-color: black; width: 100%; height: 1.2em; margin-bottom: 2px;"></div> <small>Rate filing contact person name, title</small>	<div style="background-color: black; width: 100%; height: 1.2em; margin-bottom: 2px;"></div> <small>Contact phone number</small>	<div style="background-color: black; width: 100%; height: 1.2em; margin-bottom: 2px;"></div> <small>Contact Email address</small>	
C.	Actuarial Contact (If different from above): <u>Same as above</u> <small>Actuary name, title</small>	<small>Actuary phone number</small>	<small>Actuary Email address</small>	
D.	New Rate Information (See Note #1): <u>January 1, 2014 - December 31, 2014</u> <small>New rate applicability period</small>	<u>01/01/2014</u> <small>New rate effective date</small>	<u>AWLP-129023432</u> <small>SERFF Tracking Number</small>	
E.	Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):			
Small Group				

	Response
F. Provide responses for the following questions: 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).	No
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, all required exhibits have been submitted.
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefilling.	No

Notes:

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

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Empire HealthChoice Assurance, Inc.
State:	New York
HIOS Issuer ID:	44113
Market:	Small Group
Effective Date:	January 1, 2014

- Company Contact Information

Primary Contact Name:	[REDACTED]
Primary Contact Telephone Number:	[REDACTED]
Primary Contact Email Address:	[REDACTED]

2. Scope and Purpose of the Filing

To the best of Empire's knowledge and current understanding, this filing complies with the most recent regulations and related guidance. Empire's intention is to fully comply with all applicable laws and guidance; however, the regulatory framework continues to change and evolve rapidly. To the extent relevant rules or guidance on the rules are updated or changed, amendments to this filing may be required.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA). The rates will be in-force for effective dates on or after January 1, 2014. 2014 rate changes will be implemented quarterly as discussed in more detail in Section 10: Index Rate. These rates will apply to plans offered Off-Exchange. This rate filing is not intended to be used for other purposes.

Policy Form Number(s):	NY_EPO_GA_012014
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3. Description of How the Base Rate Is Determined

The development of the Base Rate is detailed in Exhibit A - Base Rate Development. Further details on how the base rate is developed can be found in Section 4: Credibility Manual Rate Development, Section 6: Risk Adjustment and Reinsurance, Section 7: Non-Benefit Expenses, Profit and Risk, and Section 8: Average 2014 Rating Factors. A description of the methodology used to determine the base rate is as follows:

- Small Group manual rates are developed based on historical experience of Grandfathered and Non-Grandfathered business.
- The experience data is normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period based on expected distribution of membership.
- The projected claims cost is calculated by adjusting the normalized claims for the impact of benefit changes, population morbidity, trend factors, other cost of care impacts and other claim adjustments.
- The projection period is February 1, 2014 - January 31, 2015.
- Adjustments for risk adjustment and reinsurance are applied to the projected claims cost.
- Non-benefit expenses, profit, and risk are applied to the projected claims cost to determine the required projection period premium.
- The average rating factors in the projection period are applied to the projection period premium to determine the base rate.
- The base rate represents an average benefit plan and area for a single adult.

Premiums at the contract type level are determined by multiplying the base rate by the applicable factor for each of the allowable rating criteria: benefit plan, area and family composition. An example of this calculation is shown in Exhibit N - Sample Rate Calculation.

4. Credibility Manual Rate Development

Experience developed and projected herein is Empire's total Small Group Business, as well as all of Healthy New York, based on benefit expense. The rate development is shown in Exhibit A - Base Rate Development.

- Source and Appropriateness of Experience Data Used

The source data underlying the development of the manual rate consists of claims for all Grandfathered and Non-Grandfathered Small Group business, as well as all of Healthy New York, incurred during the period November 1, 2011 – October 31, 2012 and paid through December 31, 2012. Completion factors are then applied to reflect additional months of runout after December 31, 2012.

Other than completing the incurred claims, no further explicit adjustments are made to the experience data.

For more detail, see Exhibit B - Claims Experience for Manual Rate Development.

- **Adjustments Made to the Data**

The development of the projected claims is summarized in Exhibit A - Base Rate Development, items (1) - (10), and described in detail below.

The projected claims cost is calculated by multiplying the normalized claims cost by the impact of benefit changes, anticipated changes in population morbidity, and cost of care impacts. The adjustments are described below, and the factors are presented in Exhibit D - Projection Period Adjustments.

Changes in Demographics (Normalization)

The source data was normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period. The purpose of these factors is to adjust current experience to be reflective of expected claim experience in the projection period. See Section 13: Membership Projections for additional information on membership movement. The normalization factors and their aggregate impact on the underlying experience data are detailed in Exhibit C - Normalization Factors.

- **Age/Gender:** The assumed claims cost is applied by age and gender to the experience period distribution and the projection period distribution. Age/gender factors are developed from Milliman data.
- **Area/Network:** The area claims factors are developed based on an analysis of Small Group allowed claims, mapped to the prescribed 2014 rating areas using 5-digit zip code.
- **Benefit Plan:** The experience period claims are normalized to an average 2014 plan using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements. The adjustments for anticipated changes in utilization are in accordance with the DFS Instructions for the submission of 2014 premium rates, Section 5: "Induced Demand."

Changes in Benefits

Benefit changes include the following:

- **Preventive Rx (over the counter):** The claims are adjusted for 100% coverage of benefits for specific over the counter drugs obtained with a prescription from a physician.
- **Rx Adjustments:** The claims are adjusted for differences in the Rx formulary, mandatory mail order programs, and impacts for moving drugs into different tiers in the projection period relative to what is reflected in the base experience data.

Changes in the Morbidity of the Population Insured

The claims are adjusted to reflect shifts in health insurance coverage as a result of the provisions of the ACA. The market shifts, or population movements, affecting the morbidity of the Small Group market in the projection period include:

- Small Groups electing to drop coverage
- Small Group members electing to be uninsured
- Small Group members moving to Medicaid

The movement assumptions above are based on market research and assumptions on the employer opt-out and consumer uptake rates. The morbidity impacts of population movement are based on health status determined from internal risk score data.

Trend Factors

- The annual pricing trend used in the development of the rates includes the underlying cost of care claims trend (including anticipated changes in provider contracts), which has been normalized for persistent business, age/gender, and large claims, plus an estimate for leveraging, aging and a provision for adverse deviation. The claims are trended 27 months from the midpoint of the experience period, which is May 1, 2012, to the midpoint of the projection period, which is August 1, 2014.
- Empire's overall pricing trend is approximately 11.1% and consists of the following components:
 - ✦ Underlying Trend: Empire's Cost of Care Actuaries calculate the underlying trend data. This trend excludes aging, leveraging and selection adjustments, but includes the impact of new technology and cost of care initiatives. The underlying trend is roughly 7%.
 - ✦ Aging Adjustment: The aging adjustment is just under 3%.
 - ✦ Cost Sharing Leveraging Adjustment: The cost sharing leveraging adjustment is roughly 1%.

Other Claim Adjustments

The adjustments described below are presented in Exhibit E - Other Claim Adjustments.

- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.

- The cost of adding benefits for pediatric dental, pediatric vision and gym membership are included.
- Covered Lives Assessment: This indirect New York tax is a charge on all fully and self insured “covered lives”. The purpose of the Covered Lives Assessment is to raise funds for a variety of state programs and for the state Budget. The Assessment is included in claims costs for purposes of calculating the MLR.
- Healthy New York Subsidy: The projected Regulation 171 recovery for high cost claimants in the Healthy New York policy.
- Additional Non-EHBs: Clinical packages including programs such as Future Moms, Nurse Line and Healthy Lifestyles

- Capitation Payments

The underlying data includes capitation payments, which are combined with the base medical and pharmacy claims and projected at the same rate. No further adjustment is made to the capitation.

5. Credibility of Experience

The combination of both Grandfathered and Non-Grandfathered experience data most reasonably reflects Small Group claims experience under the future projection period. Actuarial judgment has been exercised to determine that rates will be developed giving full credibility to the data underlying the rates in Section 4: Credibility Manual Rate Development.

6. Risk Adjustment and Reinsurance

- Projected Risk Adjustment

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, Empire is assuming the risk for the plans in this filing are in accordance with the New York DFS risk adjustment simulation. This simulation shows that the risk adjuster payment for small group business in the HMO company is 14.3% of claims, while the risk adjuster payment for small group business in the Assurance company is -0.7% of claims. The weighted average of these percentages, based on total claims, yields a risk adjuster payment of 3.5% of claims, which is equivalent to \$13.37 PMPM in 2014, as shown in Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments.

- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The transitional reinsurance risk mitigation program collects funds from all insurance issuers and TPAs and redistributes them to high cost claimants in the Non-Grandfathered Individual market. The reinsurance contribution is equal to the national per capita reinsurance contribution rate as shown in Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments.

7. Non-Benefit Expenses, Profit and Risk

Non-Benefit expenses are detailed in Exhibit G - Non-Benefit Expenses and Profit & Risk.

- Administrative Expense

Administrative Expense contains both acquisition costs associated with the production of new business through non-broker distribution channels (direct, telesales, etc) as well as maintenance costs associated with ongoing costs for the administration of the business. Acquisition costs are projected using historical cost per member sold amounts applied to future sales estimates. Maintenance costs are assumed to be flat on a per member basis with savings from fixed cost leverage and the elimination of underwriting offset by new expenses for risk management, regulatory compliance and premium reconciliation and balancing.

- Quality Improvement Expense

The quality improvement expense represents Empire's dedication to providing the highest standard of customer care and consistently seeking to improve health care quality, outcomes and value in a cost efficient manner.

See Exhibit H - Quality Improvement/Cost Containment Programs for a description of these programs.

- Selling Expense

Selling Expense represents broker commissions and bonuses associated with the broker distribution channel using projected commission levels.

Empire recently filed a commission schedule for 2014 Small Group business.

- Taxes and Fees

- Patient-Centered Outcomes Research Institute (PCORI) Fee: The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund. For plan years ending before October 1, 2014, the fee is \$2 per member per year. Thereafter, for every plan year ending before October 1, 2019, the fee will increase by the percentage increase in National Healthcare Expenditures.
- Risk Adjustment Fee: The Risk Adjustment fee is a user fee to support the administration of the HHS operated Risk Adjustment program. The charge is \$1 per enrollee per year.
- ACA Insurer Fee: The health insurance industry will be assessed a permanent fee, based on market share of net premium, which is not tax deductible.
- Federal, state, and premium taxes are also included in the retention items.

- Profit

Profit is reflected on a post-tax basis as a percent that does not vary by product or plan.

- Changes in Exhibit 9 (formerly Exhibit 2) Expense Components

Differences in expense components between the current Exhibit 9 for Exchange plans and the Exhibit 2 submitted for inforce plans in the most recent/current Sections 3231(e)(1)/4308(c) Rate Adjustment applications are as follows:

- Projected administrative expenses, as a proportion of premium, are similar to those represented in the most recent 4308(c) and 3231(e)(1) filings. Notable differences are the increased commission, consistent with Empire's recently filed 2014 small group commission schedule; and an increase in taxes corresponding to new PPACA-related fees.

- Reconciliation with Financial Statements

Projected administrative expenses, as a proportion of premium, are similar to those represented in the 2012 financial statements. Again, differences would reflect the increased commission, consistent with Empire's recently filed 2014 small group commission schedule; and an increase in taxes corresponding to new PPACA-related fees.

8. Average 2014 Rating Factors

The required premium in the projection period is adjusted to reflect the average benefit plan, area and family composition rating factors to develop the rating period base rate. The average factors are shown in Exhibit I - Average 2014 Rating Factors and applied in line item 14 of Exhibit A - Base Rate Development.

- Benefit Plan Factors

Refer to Exhibit J - Non-Grandfathered Benefit Plan Factors.

- Area Factors

Refer to Exhibit K - Area Factors.

- Family Composition Factors

Refer to Exhibit L - Family Composition Factors.

9. Projected Loss Ratio

- Projected Federal MLR

The projected Federal MLR for the products in this filing is estimated in Exhibit O - Federal MLR Estimated Calculation. Please note that this calculation is purely an estimate and not meant to be a true measure for Federal or State MLR rebate purposes. The products in this filing represent only a subset of Empire's Small Group business. The MLR for Empire's entire book of Small Group business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to third party margins, three-year averaging, credibility, dual option, and deductible. Empire's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

10. Index Rate

- Projection Period Index Rate

The index rate, as defined in the Federal regulations, represents the average allowed claims PMPM of essential health benefits for Empire's total Small Group Non-Grandfathered Business. The first quarter projection period index rate was developed as shown in Exhibit P - Projected Index Rate Development by adjusting the projected incurred claims PMPM described in Section 4: Credibility Manual Rate Development of this memorandum. Projected trended index rates by quarter are also captured in Exhibit R - Quarterly Index and Base Rate. No benefits in excess of the essential health benefits are included in the projection period allowed claims and Exhibit R's projection period index rate. To calculate the required premium, the projection period index rate is adjusted only by the adjustments allowed per Market Reform and Payment Parameters Regulations. This development is presented in Exhibit Q - Development of Required Premium from Index Rate.

- Quarterly Index and Base Rate

Quarterly index and base rate changes will be implemented. Refer to Exhibit R - Quarterly Index and Base Rate.

11. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values included in Addendum II - Listing of Plans in the Risk Pool are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially-equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. Benefits for Plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

The Actuarial Value (AV) Metal Values for inforce plans are determined in the same fashion.

12. Actuarial Value Pricing Values

The Initial Plan Pricing AVs in Addendum III - Development of Plan-Level Premium Rates by Census Tier are developed using WellPoint's benefit relativity factor model, which is a modified Milliman model. The program allows induced utilization to be turned off and the DFS' recommended induced utilization amounts were used.

13. Membership Projections

Membership projections are developed using a population movement model and adjustments for sales expectations. This model projects the membership in the projection period by taking into account:

- Small Groups dropping coverage
- Small Group members opting out of coverage
- Small Group members to Medicaid as a result of expanded Medicaid eligibility

The plan distribution is based on assumed metal tier and network distributions.

Refer to Exhibit D - Projection Period Adjustments for the projected morbidity changes from population movement.

14. Pricing of Make Available Riders

Pricing methods for each of the required make-available riders are discussed below:

- Domestic Partner Rider

This rider is currently offered at no additional cost because it is assumed that the use of the appropriate contract type will cover the cost of this additional member. Empire intends to continue that practice of no additional charge going forward.

- Unlimited SNF Days Rider

The filed 2014 rates for Empire's current Small Group products apply between 0.05% and 0.14% for this additional SNF coverage. Empire proposes a rate of 0.07% to increase SNF days to be unlimited going forward, which is a weighted average of the range.

- Dependent Coverage through the Age of 29 Rider

The filed 2014 rates for Empire's current Small Group products apply between 3% and 10% on the contract types that have children for this coverage. A predominance of these plans charge approximately 4%, so going forward Empire proposes a charge of 4% of parent/child(ren) and family contracts for this coverage, which is a weighted average of the range.

- Opt-out of Contraceptives Rider

An enterprise study determined that contraceptive benefits are worth about 0.7% of Empire's average claim PMPM as developed for 2014. Empire proposes a rate of 0.7% to remove contraceptive coverage.

- Member Opt-in of Contraceptives Coverage

For a Small Group that opts out of contraceptive coverage, the members may opt to purchase this coverage directly from Empire. Empire proposes a single rate of \$3.20 (which is $0.7\% * 382.04 * 1.1985 = \text{opt-out rate} * \text{line 10 from Exhibit A} * \text{result of Exhibit M}$) to add back contraceptive coverage, consistent with the average amount removed from the group's rate.

15. State Actuarial Memorandum Requirements

For a mapping of each Actuarial Memorandum Requirement of the State of New York to its location in this submitted Actuarial Memorandum, please refer to Addendum I - State Requirements.

For a listing of all plans included in the risk pool, refer to Addendum II - Listing of Plans in the Risk Pool.

For a development of plan-level premium rates in the format requested by the DFS, refer to Addendum III - Development of Plan-Level Premium Rates by Census Tier.

16. Actuarial Certification

I, [REDACTED] am an actuary for Empire. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The filing is in compliance with all applicable laws and regulations of the State of New York;

(2) The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

- ✦ ASOP No. 5, Incurred Health and Disability Claims
- ✦ ASOP No. 8, Regulatory Filings for Health Plan Entities
- ✦ ASOP No. 12, Risk Classification
- ✦ ASOP No. 23, Data Quality
- ✦ ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ✦ ASOP No. 41, Actuarial Communications

(3) The expected loss ratio incorporated into the rate tables meets the minimum

(4) The benefits are reasonable in relation to the premiums charged; and

(5) The rates are not unfairly discriminatory.

[REDACTED]
[REDACTED]

May 13, 2013

Date

Exhibit A - Base Rate Development

Effective January 1, 2014

Empire HealthChoice Assurance, Inc. Small Group

	<u>Paid Claims</u>	
1) Experience Period Cost PMPM	\$ 404.78	Exhibit B
2) x <u>Normalization Factor</u>	<u>0.7957</u>	Exhibit C
3) = Normalized Claims	\$ 322.08	= (1) x (2)
4) x Benefit Changes	0.9518	Exhibit D
5) x Morbidity Changes	1.0062	Exhibit D
6) x Medical Trend Factor	1.2669	Exhibit D
7) x <u>Other Cost of Care Impacts</u>	<u>1.0000</u>	Exhibit D
8) = Projected Claim Cost	\$ 390.78	= (3) x (4) x (5) x (6) x (7)
9) + Other Claim Impacts	(\$8.74)	Exhibit E
10) = Claims Projected to Projection Period	\$ 382.04	= (8) + (9)
11) + Risk Mitigation - Contributions and Payments	(\$8.27)	Exhibit F
12) + <u>Selling Expense, Administration and Other Retention Items {1}</u>	<u>\$79.21</u>	Exhibit G
13) = Required Premium in Projection Period	\$ 452.98	= (10) + (11) + (12)
14) (a) x Average Contract Size Factor in Projection Period	1.7630	Exhibit H
(b) ÷ Average Rating Factors (Rating Tier/Area/Plan) in Projection Period	1.4710	Exhibit H
15) = Base Rate (Average Plan-Level)	\$ 542.90	= (13) x (14a) ÷ (14b)
16) Projected Loss Ratio (Conventional Basis)	82.5%	= [(10) + (11)] ÷ (13)

NOTES:

{1} Equivalent to PMPM expenses on Exhibit G + % of premium expenses on Exhibit G applied to Required Premium (Row 13 above).

Exhibit B - Claims Experience for Manual Rate Development

Empire HealthChoice Assurance, Inc.
Small Group

Incurred November 1, 2011 through October 31, 2012
Paid through December 31, 2012

Healthy New York and SG HMO In-Area Business:

PAID CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
\$ 718,221,511	\$ 166,352,891	\$ 14,960,832	\$ 52,990	\$ 733,182,343	\$ 166,405,881	\$ 4,400,705	\$ 903,988,929	2,233,257	\$ 404.78	

ALLOWED CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
\$ 904,805,783	\$ 211,479,742	\$ 18,420,701	\$ 66,206	\$ 923,226,484	\$ 211,545,948	\$ 4,400,705	\$ 1,139,173,137	2,233,257	\$ 510.09	

Exhibit C - Normalization Factors

Empire HealthChoice Assurance, Inc.
Small Group

Experience Period: November 1, 2011 through October 31, 2012

<u>Normalize to population expected in 2014</u>			
<i>Average claim factors based on future population as compared to experience period population:</i>			
	Average Claim Factors		Normalization
	Experience Period Population	Future Population	Factor
Age/Gender	1.1055	1.1055	1.0000
Area/Network	1.0011	0.9106	0.9096
Benefit Plan	1.2194	1.0668	0.8748
Total	1.3495	1.0739	0.7957

Exhibit D - Projection Period Adjustments

Empire HealthChoice Assurance, Inc. Small Group

Impact of Changes Between Experience Period and Projection Period:

	<u>Adjustment Factor</u>
<u>Benefit changes</u>	
Preventive Rx (over the counter)	1.0005
Eliminate Pre-Ex	1.0000
<u>Rx Adjustments {1}</u>	<u>0.9513</u>
Total Benefit Changes	0.9518
<u>Morbidity changes</u>	
Total Morbidity Changes	1.0062
<u>Cost of care impacts</u>	
Annual Medical/Rx Trend Rate	11.09%
# Months of Projection	27
Trend Factor	1.2669

NOTES:

{1} Includes Rx formulary, mandatory mail order

Exhibit E - Other Claim Adjustments

Empire HealthChoice Assurance, Inc. Small Group

<i>Adjustments to projection period claims to reflect covered benefits not included in experience period data:</i>	
	<u>PMPM</u>
Rx Rebates	(\$7.20)
Pediatric Dental	\$3.62
Pediatric Vision	\$0.89
Gym Membership	\$0.99
Covered Lives Assessment	\$7.28
Healthy New York Subsidy	(\$18.04)
<u>Additional Non-EHBs {1}</u>	<u>\$3.72</u>
Total	(\$8.74)

{1} The 'Additional Non-EHBs' adjustment above reflects ONLY additional costs beyond those already captured in line Item 8 of Exhibit A. Line Item 8 of Exhibit A includes \$0.36 of embedded Non-EHB medical costs resulting from inclusion in the experience data and/or the normalization process.

Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments

Empire HealthChoice Assurance, Inc.
Small Group
Effective January 1, 2014

<u>Risk Adjustment:</u>			
Description	Transfers funds from lowest risk plans to highest risk plans		
Participants	Non-Grandfathered Individual and Small Group plans (inside and outside Exchange) are eligible		
PMPM	Net Transfer		
Federal Program	(\$13.37)		
	<u>Note:</u>		
	It is assumed the risk for the plans included in this rate filing is worse overall than other plans within this market.		
<u>Reinsurance:</u>			
Description	Provides funding to plans that enroll highest cost individuals		
Participants	All insurance issuers and TPAs contribute funds		
	Non-Grandfathered Individual plans (inside and outside Exchange) are eligible for payments		
PMPM	Contributions Made	Payments Received	
Federal Program	\$5.10	\$0.00	<i>Small Group Plans contribute funds but only Individual Plans are eligible to receive payments</i>
	<u>Source:</u>		
	HHS estimates a national per capita contribution rate of \$5.25 per month (\$63 per year) in benefit year 2014 (per Payment Parameter Rule).		
Grand Total of All Risk Mitigation Programs			(\$8.27)

NOTES:

\$5.10 = \$5.25 * (11 months/12months) + \$3.50 * (1 months/12 months)

\$5.25 = 2014 contribution

\$3.50 = 2015 contribution

Exhibit G - Non-Benefit Expenses and Profit & Risk

Empire HealthChoice Assurance, Inc. Small Group

	<u>PMPM</u>	<u>% Premium</u>
Administrative Costs	\$29.01	
Quality Improvement Expense	\$2.61	
Selling Expense	\$8.66	
ACA Related Fees:		
PCORI Fee	\$0.17	
Risk Adjustment User Fee	\$0.08	
ACA Insurer Fee		2.55%
Exchange User Fee		0.00%
Premium Tax		2.99%
Federal/State Taxes		1.05%
Profit (Post-Tax)		1.95%
Total	\$40.53	8.54%

Exhibit H - Quality Improvement/Cost Containment Programs

Empire HealthChoice Assurance, Inc. Small Group

Radiology and Cardiac	Prospective clinical appropriateness reviews for diagnostic imaging .
Specialty Pharmacy Program	Prospective clinical appropriateness reviews for specialty pharmaceuticals.
OptiNet	A web-based application supports collaboration and more informed decision-making by physicians and members when selecting diagnostic imaging facilities.
Specialty Care Shopper Program	A member-engagement program that aims to provide members with choices between high-cost and low-cost imaging facilities with equal or better quality by information sharing and proactive member call outs.
Sleep Program	A Sleep Medicine Management Program that conducts pre-service clinical appropriateness review.
Physical Therapy / Occupational Therapy (PT/OT) Management Program	The PT/OT Management program involves prior review of services with regard to established medical policy and clinical guidelines.
Discharge Planning	Discharge planning activities are comprehensive in nature and consist of organizing and transitioning care to lesser acute facilities, counseling patients on discharge instructions, care coordination, etc.
Care coordination	Nurses interface with the clinicians on a member's care team when members are admitted to the hospital.
Radiology Benefits Management Program	The Radiology Benefits Management program involves prior review of services with regard to established medical policy and clinical guidelines.
Pharmacy Prior Authorization	Prior authorization involves review of submitted pharmacy claims to ensure the intended use is FDA approved or recognized in a major compendia as being safe and effective in order to be a covered benefit.
Specialty Pharmacy Drug Reviews	Pre-certification process of specialty medications.
Care Management	Care management staff coordinates quality health care services and the optimization of benefits through a realistic, cost-effective, and timely care management plan.
ComplexCare	The ComplexCare program is a proactive, collaborative, member-centric model of care management in which chronic care management is emphasized for those members with chronic or multiple non-disease management types of condition(s) at future high risk.
ConditionCare (Disease Management) Program	A program to help maximize member health status, improve health outcomes, and control health care expenses associated with the following prevalent conditions: Asthma (pediatric and adult), Diabetes (pediatric and adult), Heart Failure (HF), Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD).
MyHealth Coach Program	MyHealth Coach nurses serve as a central point of contact for individuals who have questions about a health care related topic, condition or concern, a question about benefits, a concern about claim payment or language in an 'Explanation of Benefits' statement.
Chronic Kidney Disease	The Kidney Disease Management: Chronic Kidney Disease (late stage) and End Stage Renal Disease program is designed to Improve participant's quality of life and clinical outcomes, slowing the progression of the disease and controlling costs related to hospitalizations, emergency room admissions and significant complications.
Nurseline	24/7 NurseLine is staffed exclusively by Registered Nurses who assist consumers in choosing the most appropriate use of health care resources, applying self care, learning about specific medical conditions, treatment options and side effects associated with prescription drugs, and providing valuable lifestyle management and nutrition information.
Healthy Lifestyles	Lifestyle management/health & wellness program that includes web-based programs & tools, telephonic lifestyle coaching and access to a national network of fitness centers.
MyHealth Advantage (MHA)	MHA comprises quality-based communications to members, physicians, health care plans, and pharmacists (as needed) on topics such as best-practice therapeutic interventions in member medical care.
Health IT	IT expenses in support of the programs noted above which have been identified as executing Quality Improvement activities.
Chiropractic Benefit Management Program	The Chiropractic benefit Management program involves retrospective review of services with regard to established medical policy and clinical guidelines.
Gym Reimbursement Program	The Gym Reimbursement program involves partially reimbursing the Subscriber and the Subscriber's Covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities and which maintain equipment and programs that promote cardiovascular wellness.

Exhibit I - Average 2014 Rating Factors

Empire HealthChoice Assurance, Inc.
Small Group

Effective January 1, 2014

<i>Average 2014 rating factors for 2014 population:</i>	
	Average Rating Factor
Average Contract Size	1.7630
Contract Type	1.4710
Area	1.0000
Benefit Plan	1.0000
Total (Contract Type x Area x Benefit Plan) =	1.4710
Conversion Factor	1.1985

Exhibit J - Non-Grandfathered Benefit Plan Factors

Empire HealthChoice Assurance, Inc.

Small Group

Effective January 1, 2014

Off-Exchange Plans:		
<u>Metal Level</u>	<u>HIOS Standard Component Plan ID</u>	<u>Benefit Plan Factor</u>
Bronze	44113NY0380004	0.7740
	44113NY0380005	0.7294
	44113NY0380009	0.7740
	44113NY0380010	0.7294
Silver	44113NY0380002	0.9068
	44113NY0380003	0.9480
	44113NY0380001	0.8950
	44113NY0380007	0.9068
	44113NY0380008	0.9480
	44113NY0380006	0.8950
Gold	80519NY0200001	1.0751
	80519NY0080001	0.8987
	80519NY0200002	1.0751
	80519NY0080002	0.8987

Benefit Plan Factors above reflect plan by plan differences from the index rate for allowable adjustments as described in detail in the Market Reform and Payment Parameters Regulations and illustrated in Exhibit Q. The weighted average of these adjustments for the entire risk pool included in this rate filing is detailed in Exhibit I.

Exhibit K - Area Factors

Empire HealthChoice Assurance, Inc.
Small Group
Effective January 1, 2014

Rating Area Description	Narrow Rating Factor
Albany	0.9435
Long Island	0.9335
Mid-Hudson	1.1051
New York City	1.0332
Upstate	1.4043

NOTES:

{1} Network adjustments (e.g., discount differences) are included in the benefit plan factors as shown in Exhibit J.

Exhibit L - Family Composition Factors

Empire HealthChoice Assurance, Inc.

Small Group

Effective January 1, 2014

Contract Type	Composition Factor
Single	1.00
Single + Spouse	2.00
Single + Child(ren)	1.70
Single + Spouse + Child(ren)	2.85

Exhibit M - Development of Conversion Factor

Empire HealthChoice Assurance, Inc.

Small Group

Effective January 1, 2014

Contract Type	Projected Contract Distribution	a) Prescribed Premium Relativity	b) Average Contract Size	c) Conversion Factor: (a) ÷ (b)
Individual	65%	1.00	1.00	
Husband/Wife	14%	2.00	2.00	
Parent/Child(ren)	5%	1.70	2.90	
Family	16%	2.85	4.30	
All Contracts	100%	1.4710	1.7630	1.1985

Exhibit N - Sample Rate Calculation

Empire HealthChoice Assurance, Inc. Small Group

Group Name: Sample Group
Effective Date: 01/01/2014
On/Off Exchange: Off
Metal Level: Bronze
Plan ID: 44113NY0380004
Rating Area: Albany
Network: Narrow
Group Census:

Calculation of Monthly Premium:

Base Rate =	\$	542.90	Exhibit A
x Benefit Plan Factor		0.7740	Exhibit J
<u>x Area Factor</u>		<u>0.9435</u>	Exhibit K
Base Rate Adjusted for Plan/Area =	\$	396.46	

Final Monthly Premium PMPM:

<u>Contract Type</u>	<u>Family Composition Factor (Exhibit L)</u>	<u>Monthly Rate</u>
Single	1.00	\$ 396.46
Single + Spouse	2.00	\$ 792.92
Single + Child(ren)	1.70	\$ 673.98
Single + Spouse + Child(ren)	2.85	\$ 1,129.91

Exhibit O - Federal MLR Estimated Calculation

Empire HealthChoice Assurance, Inc. Small Group

Numerator:

Incurred Claims	\$382.04	Exhibit A
+ Quality Improvement Expense	\$2.61	Exhibit G
+ Risk Corridor Contributions	\$0.00	
+ Risk Adjustment Contributions	\$0.00	Exhibit F
- Reinsurance Receipts	\$0.00	Exhibit F
- Risk Corridor Receipts:	\$0.00	
<u>- Risk Adjustment Receipts:</u>	<u>\$13.37</u>	Exhibit F
= <i>Estimated Federal MLR Numerator</i>	\$371.28	

Denominator:

Premiums	\$452.98	Exhibit A
- Federal and State Taxes	\$4.76	Exhibit A (Premium) and Exhibit G (Taxes)
- Premium Taxes	\$13.54	Exhibit A (Premium) and Exhibit G (Taxes)
- Reinsurance Contributions	\$5.10	Exhibit F
<u>- Licensing and Regulatory Fees</u>	<u>\$11.80</u>	Exhibit A (Premium) and Exhibit G (Fees)
= <i>Estimated Federal MLR Denominator</i>	\$417.78	

Estimated Federal MLR

88.87%

NOTES:

The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

- 1) The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.
- 2) Not all numerator/denominator components are captured above (for example, third party vendors excess reimbursement, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).
- 3) Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.
- 4) Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule

Exhibit P - Projected Index Rate Development

Effective January 1, 2014

Empire HealthChoice Assurance, Inc.
Small Group

1) Projected Paid Claim Cost	\$	390.78	Exhibit A, Line Item 8
2) <u>- Non-EHBs Embedded in Line Item 1) Above</u>		<u>\$0.36</u>	Exhibit E (see footnote in Exhibit E)
3) = Projected Paid Claims, Excluding ALL Non-EHBs	\$	390.42	
4) + Rx Rebates		(\$7.20)	Exhibit E
5) <u>+ Additional EHBs {1}</u>		<u>\$5.50</u>	Exhibit E
6) = Projected Paid Claims Reflecting <i>only</i> EHBs	\$	388.72	
7) <u>÷ Paid to Allowed Ratio</u>		<u>0.7576</u>	
8) = Projected Allowed Claims Reflecting <i>only</i> EHBs		\$513.09	= Index Rate

NOTE:

{1} Pediatric Dental, Pediatric Vision and Gym

Exhibit Q - Development of Required Premium from Index Rate

Effective January 1, 2014

Empire HealthChoice Assurance, Inc. Small Group

	<u>Weighted Average for Risk Pool</u>	
1) Index Rate - Federal Definition	\$513.09	Exhibit P
2) <u>x Paid to Allowed Ratio</u>	<u>0.7576</u>	Exhibit P
3) = Projected Paid Claims Reflecting <i>only</i> EHBs	\$388.72	
<u>Allowable Index Rate Adjustments {1} {2}: </u>		
4) x Benefit Adjustments	1.0000	
5) + Non-EHBs	(\$6.68)	Exhibit E
6) x Catastrophic Adjustment	1.0000	
7) x Network Adjustment	1.0000	
8) + Risk Mitigation - Contributions and Payments	(\$8.27)	Exhibit F
9) + <u>Selling Expense, Administration and Other Retention Items</u>	<u>\$79.21</u>	Exhibit G (also see Exhibit A, Line item 12)
10) = Required Premium in Projection Period	\$452.98	Ties to Exhibit A, Line item 13

NOTES:

- {1} Allowable adjustments to the index rate as made above are in accordance with the Market Reform and Payment Parameters Regulations.
- {2} The above illustrates the allowable adjustments to the average single risk pool index rate as included in this rate filing. These adjustments may vary on a plan by plan basis and such variances are captured in the benefit plan factors as summarized in Exhibit J.
- {3} Plan-level rates are obtained by multiplying the base rate as shown in line item 15 of Exhibit A by the benefit plan factors illustrated in Exhibit J. Further allowable adjustments (area and family composition) are applied to arrive at final premium rates.

Exhibit R - Quarterly Index and Base Rate

Empire HealthChoice Assurance, Inc. Small Group

	Rates Effective:				
	1Q14	2Q14	3Q14	4Q14	Wtd Avg
Renewing Member Months	558,314	558,314	558,314	558,314	2,233,257
Quarterly Allowed Trend		2.43%	2.43%	2.43%	
Index Rate	\$513.09	\$ 525.56	\$ 538.33	\$ 551.41	\$ 532.10
Quarterly Paid Trend		2.80%	2.80%	2.80%	
Base Rate	542.9	\$ 558.10	\$ 573.73	\$ 589.79	

NOTES:

{1} The 1Q14 index rate was derived in Exhibit P.

{2} The 1Q14 index rate is assumed to increase with quarterly allowed trend as illustrated above.

{3} The 1Q14 base rate was derived in Exhibit A.

{4} The 1Q14 base rate is assumed to increase with quarterly paid trend as illustrated above. This trend rate differs from the index rate trend in that it includes anticipated changes for non-EHBs, deductible leveraging, fees, and risk mitigation programs.

{5} Minor rate variances may occur due to differences in rounding methodology.

ADDENDUM I: STATE REQUIREMENTS

Mapping of each Actuarial Memorandum Requirement of the State of New York to its location in this submitted Actuarial Memorandum

Actuarial Memorandum Requirement	Location in this Submitted Actuarial Memorandum
(h) The process used for the determination of the Index Rate and premium rates for both on-	Addendum III - Development of Plan-Level Premium Rates by Census Tier
(1) Average PMPM Incurred Claims for the latest experience period.	
(2) Average AV Pricing Value determined for all inforce plans in effect during the latest experience period, based on member-months in the experience period for each inforce plan.	
(3) Average Induced Demand Adjustment factor determined based on member-months in the experience period for each inforce plan.	
(4) Assumptions as to average annual claim trend rates for all components, including inflation, utilization, leverage, and other factors.	
(5) Projection trend factor from midpoint of experience period to midpoint of applicability for First Quarter 2014 premium rates.	
(6) Projected Average PMPM Incurred Claims determined from (1) and (5) above.	
(7) Market-wide index rate adjustments as discussed in Section 6, not already reflected.	
(8) For all inforce plans combined, determine the "Index" PMPM Claim Rate. This step reflects the Projected PMPM Incurred Claims per (6) above with Market-Wide adjustments prescribed in HHS regulation per (7) above.	
(9) Determine the starting point PMPM Claim Rate for each Non-Grandfathered Plan (both On-Exchange and Off-Exchange) by multiplying the Index PMPM Claim Rate for all inforce plans combined per (8) above by the ratio of (A) to (B), as follows: (A) The AV Pricing Value for each Non-Grandfathered Plan, both On-Exchange and Off-Exchange, at each of the Metal Tier levels; (B) The Average AV Pricing Value per (2) above for all inforce plans.	
(10) Plan-Design Level Adjustments for the various differences in characteristics as described above.	
(11) Plan-Design Level Adjustments for Administrative Costs and Profit Margins per Exhibit 9.	
(12) Preliminary PMPM Premium Rate for each Non-Grandfathered Plan, as determined from items (10) and (11) above, e.g., (10) divided by 100% less (11).	
(13) Final (all regions combined) Premium Rates for all Non-Grandfathered Plans for Employees only, for Employees and Spouse, for Employees and Child(ren) and for Employees and Spouse and Child(ren), based on census factors prescribed by the Department.	
(14) Final Premium Rates for each Non-Grandfathered Plans for each applicable rating region based on the area factors by region as determined by the Company's' actuary, and as explained in the Actuarial Memorandum.	Rate Manual
(15) Final Premium rates for subsequent quarters in calendar year 2014.	

(i) Supporting details on the key assumptions and additional information to be included in actuarial memorandum:	See below.
(1) Assumptions on annual claim trend rates, including if available, information on experienced annualized claim trend rates on allowed charges;	Section 4: Credibility Manual Rate Development
(2) Justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic (aging) change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components that is not part of the Market-Wide Index Rate Adjustments;	Section 4: Credibility Manual Rate Development
(3) Assumptions on Administrative costs components, including (a) explanations for differences in expense components between the current Exhibit 9 for Non-Grandfathered plans and the Exhibit 2 submitted for inforce plans in the most recent/current Sections 3231(e)(1)/4308(c) Rate Adjustment submission, and (b) reconciliation with administrative costs information reported in latest financial statements; and	Section 7: Non-Benefit Expenses, Profit and Risk
(4) Assumptions on profit margins or contribution to surplus, including a discussion on Return on Equity.	Section 7: Non-Benefit Expenses, Profit and Risk
(5) Details as to adjustments to Actuarial Values determined based on HHS AV Calculator for inforce plans.	Section 11: Actuarial Value Metal Values
(6) SERFF Number of the associated QHP Template filing.	Not Applicable
(7) Details as to the restructuring of the various "composite" premium rates into separate premium rates for the various census cells, i.e. Employees only, Employees and Spouse, Employees and Child(ren) and Employees and Spouse and Child(ren), using the census factor tier factors prescribed by the Department.	Section 8: Average 2014 Rating Factors
(8) Details as to the determination of the premium rates by the standardized rating regions.	Section 8: Average 2014 Rating Factors
(9) Details as to adjustments to the premium rates for the impact of risk adjustments, including the results for the simulations performed by the Department and the support for the adjustments introduced.	Section 6: Risk Adjustment and Reinsurance
(10) Details and support on any other adjustments deemed necessary by the Company's actuary.	Section 4: Credibility Manual Rate Development
(11) If the source data for the determination of the premium rates for the Exchange plans is other than the actual claims experience under Non-Grandfathered/Grandfathered plans, indicate the source of this data (e.g., the publication, organization, or consultants), and the applicability of this source data.	Section 4: Credibility Manual Rate Development

Addendum II - Listing of Plans in the Risk Pool

Empire HealthChoice Assurance, Inc. Small Group

On or Off Exchange	HIOS Plan Name	Metal Tier	Metal AV Value	Cost Sharing Features			
				In Network Deductible	In Network Coins.	In Network OOP Max	Out of Network Coverage
Off Exchange	Empire Core Guided Access Plus w HSA gugb	Bronze	0.6021	\$3,500	20%	\$6,350	No
Off Exchange	Empire Core Guided Access Plus w HSA gwgb	Bronze	0.5885	\$4,500	30%	\$6,350	No
Off Exchange	Empire Essential Guided Access Plus gwoa	Silver	0.7003	\$1,500	35%	\$6,350	No
Off Exchange	Empire Essential Guided Access Plus w/Dental gwoa	Silver	0.7003	\$1,500	35%	\$6,350	No
Off Exchange	Empire Essential Guided Access Plus w HSA gbcb	Silver	0.6835	\$2,500	20%	\$4,500	No
Off Exchange	Empire Preferred Guided Access Plus w HSA gsqa	Gold	0.7836	\$1,250	10%	\$6,350	No
Off Exchange	Empire Healthy New York HMO ggza	Gold	0.7900	\$600	20%	\$4,000	No

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 1)

Empire HealthChoice Assurance, Inc. Small Group

1)	Average PMPM Incurred Claims	\$403.39
2)	Average AV Pricing Value of All Inforce Plans	1.2195
3)	Average Induced Demand Adjustment Factor for All Inforce Plans	1.1253
4)	Average Annual Trend Rate Components	
	a) Annual Trend Assumption	11.1%
	b) Number of Trend Months	27
5)	Projected Trend Factor: $[1 + (4)(a)] ^ [(4)(b) \div 12]$	1.2669
6)	Projected PMPM Incurred Claims: (1) x (5)	\$511.06
7)	Market-Wide Index Rate Adjustments {1}	
	a) Benefit Changes	0.9518
	b) Changes in Provider Network	0.9092
	c) Fee Schedule Changes	1.0000
	d) Utilization Management Changes	1.0000
	e) Age/Gender Normalization	1.0000
	f) Morbidity Changes	1.0062
	g) Area/Network Normalization	1.0004
	h) Federal Risk Adjustment Program Impact	0.9655
	i) Federal Transitional Reinsurance Program Recovery	1.0133
	j) Credibility Adjustment	1.0000
	k) Rx Rebates	0.9816
	l) Induced Demand from Cost Share Reductions	1.0000
	m) Grace Period	1.0000
	n) <u>Total Market-Wide Index Rate Adjustments</u>	<u>0.8365</u>
8)	"Index" PMPM Claim Rate: (6) x (7)(o)	\$427.52
9)	Starting PMPM Claim Rate for Each Non-Grandfathered Plan	Part 2
10)	Plan-Level Adjustments for Benefit Characteristics	Part 2
11)	Plan-Level Adjustments for Administrative Costs & Profit Margin	Part 2
12)	Preliminary PMPM Premium Rate for Each Non-Grandfathered Plan	Part 2
13)	Final Plan-Level Premium Rates by Census Tier	Part 2
14)	Final Plan-Level Premium Rates by Census Tier and Rating Region	Rate Manual
15)	Premium Rates for Subsequent Quarters in Calendar Year 2014	Rate Manual

NOTES:

{1} For descriptions of these adjustments, refer to the Actuarial Memorandum, "Credibility Manual Rate" section.

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 2)

Empire HealthChoice Assurance, Inc. Small Group

HIOS Plan Name	8) "Index" PMPM Claim Rate, from Page 1	9) Starting PMPM Claim Rate for Each Non-Grandfathered Plan				10) Plan-Level Adjustments for Benefit/Plan Characteristics		
		a) Initial Plan Pricing AV {1}	b) Adjusted Plan Pricing AV {2}	c) Average Experience Period Pricing AV	d) Starting PMPM Claim Rate: (8) x [(9)(b) ÷ (9)(c)]	a) Benefit Adjustment {3}	b) Order of Operations and Rounding Adjustment	c) PMPM Claim Rate After Adjustments: (9)(d) x (10)(a-b)
Empire Core Guided Access Plus w HSA gugb	\$427.52	0.7765	0.7948	1.2195	\$278.64	1.0388	0.9997	\$289.34
Empire Core Guided Access Plus w HSA gwgb	\$427.52	0.7290	0.7473	1.2195	\$262.00	1.0412	0.9994	\$272.64
Empire Essential Guided Access Plus gwoa	\$427.52	0.9176	0.9359	1.2195	\$328.10	1.0329	1.0002	\$338.98
Empire Essential Guided Access Plus w/Dental gwoa	\$427.52	0.9176	0.9359	1.2195	\$328.10	1.0799	1.0002	\$354.38
Empire Essential Guided Access Plus w HSA gbcb	\$427.52	0.9050	0.9233	1.2195	\$323.69	1.0333	1.0002	\$334.55

{1} The Initial Plan Pricing AVs are computed prior to the plan-level adjustments in (10) and (11) and are not normalized relative to the reference plan; therefore, the values in this column will not match the benefit plan factors in Exhibit J or the Plan Pricing AVs in URRT.

{2} The Adjusted Plan Pricing AVs include the cost of Pediatric Dental, Pediatric Vision and Gym Membership.

{3} Benefit Adjustments include the Covered Lives Assessment, Healthy New York Subsidy and benefits in addition to Essential Health Benefits.

{4} For the development of the conversion factor, refer to Exhibit M.

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 2)

Empire HealthChoice Assurance, Inc. Small Group

HIOS Plan Name	11) Plan-Level Adjustments for Administrative Costs and Profit Margins, as a % of Premium			12) Preliminary PMPM Premium Rate for Each Non-Grandfathered Plan: (10) ÷ [1 - (11)(c)]
	a) Administrative Costs, excluding Profits	b) Profit/Contribution to Surplus Margins	c) Total Administrative Expense Load: (11)(a) + (11)(b)	
Empire Core Guided Access Plus w HSA gugb	14.49%	3.00%	17.49%	\$350.66
Empire Core Guided Access Plus w HSA gwgb	14.49%	3.00%	17.49%	\$330.42
Empire Essential Guided Access Plus gwoa	14.49%	3.00%	17.49%	\$410.82
Empire Essential Guided Access Plus w/Dental gwoa	14.49%	3.00%	17.49%	\$429.48
Empire Essential Guided Access Plus w HSA gbcb	14.49%	3.00%	17.49%	\$405.45

{1} The Initial Plan Pricing AVs are computed prior to the plan-level adjustments in (10) and (11) and are not normalized relative to the reference plan; therefore, the values in this column will not match the benefit plan factors in Exhibit J or the Plan Pricing AVs in URRT.

{2} The Adjusted Plan Pricing AVs include the cost of Pediatric Dental, Pediatric Vision and Gym Membership.

{3} Benefit Adjustments include the Covered Lives Assessment, Healthy New York Subsidy and benefits in addition to Essential Health Benefits.

{4} For the development of the conversion factor, refer to Exhibit M.

Addendum III - Development of Plan-Level Premium Rates by Census Tier (Part 2)

Empire HealthChoice Assurance, Inc. Small Group

HIOS Plan Name	13) Final Premium Rates (all regions combined)					
	a) Conversion Factor {4}	b) Single Premium Rate: (12) x (13)(a)	c) Individual: (13)(b) x 1.00	d) Husband/ Wife: (13)(b) x 2.00	e) Parent/ Child(ren): (13)(b) x 1.70	f) Family: (13)(b) x 2.85
Empire Core Guided Access Plus w HSA gugb	1.199	\$420.27	\$420.27	\$840.54	\$714.46	\$1,050.68
Empire Core Guided Access Plus w HSA gwgb	1.199	\$396.01	\$396.01	\$792.02	\$673.22	\$990.03
Empire Essential Guided Access Plus gwoa	1.199	\$492.37	\$492.37	\$984.74	\$837.03	\$1,230.93
Empire Essential Guided Access Plus w/Dental gwoa	1.199	\$514.73	\$514.73	\$1,029.46	\$875.04	\$1,286.83
Empire Essential Guided Access Plus w HSA gbcb	1.199	\$485.93	\$485.93	\$971.86	\$826.08	\$1,214.83

{1} The Initial Plan Pricing AVs are computed prior to the plan-level adjustments in (10) and (11) and are not normalized relative to the reference plan; therefore, the values in this column will not match the benefit plan factors in Exhibit J or the Plan Pricing AVs in URRT.

{2} The Adjusted Plan Pricing AVs include the cost of Pediatric Dental, Pediatric Vision and Gym Membership.

{3} Benefit Adjustments include the Covered Lives Assessment, Healthy New York Subsidy and benefits in addition to Essential Health Benefits.

{4} For the development of the conversion factor, refer to Exhibit M.