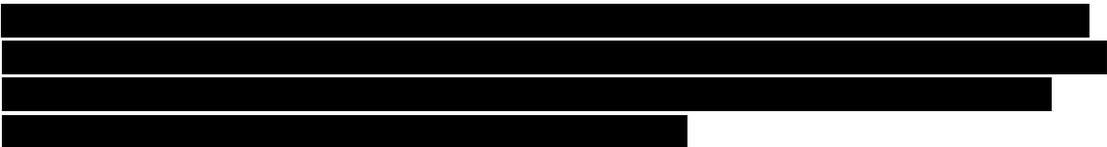


State: New York **Filing Company:** Empire HealthChoice HMO, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only
 - HMO
Product Name: NY SG Off-Exch 0513 - Art44
Project Name/Number: SG Off-Ex 0513 Art 44/SG Off-Ex 0513 Art 44

Filing at a Glance

Company: Empire HealthChoice HMO, Inc.
 Product Name: NY SG Off-Exch 0513 - Art44
 State: New York
 TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)
 Sub-TOI: HOrg02G.004F Small Group Only - HMO
 Filing Type: Off Exchange NG Forms & Rates
 Date Submitted: 05/15/2013
 SERFF Tr Num: AWLP-129002174
 SERFF Status: Pending State Action
 State Tr Num: 2013050123
 State Status:
 Co Tr Num: NY SG OFF-EXCH 0513 ART44
 Implementation: 01/01/2014
 Date Requested:

Author(s): 

Reviewer(s): 

Disposition Date:
 Disposition Status:
 Implementation Date:

State Filing Description:

State: New York **Filing Company:** Empire HealthChoice HMO, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only
 - HMO
Product Name: NY SG Off-Exch 0513 - Art44
Project Name/Number: SG Off-Ex 0513 Art 44/SG Off-Ex 0513 Art 44

General Information

Project Name: SG Off-Ex 0513 Art 44	Status of Filing in Domicile:
Project Number: SG Off-Ex 0513 Art 44	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: 05/20/2013	
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 Art44

Company and Contact

Filing Contact Information

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

Filing Company Information

Empire HealthChoice HMO, Inc.	CoCode: 95433	State of Domicile: New York
1 Liberty Plaza	Group Code: 671	Company Type: Life,
14th Floor	Group Name: WellPoint Inc Group	Accident, Health
New York, NY 10006	FEIN Number: 13-3874803	State ID Number:
[REDACTED] [Phone]		

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State Specific

State: New York **Filing Company:** Empire HealthChoice HMO, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only
- HMO
Product Name: NY SG Off-Exch 0513 - Art44
Project Name/Number: SG Off-Ex 0513 Art 44/SG Off-Ex 0513 Art 44

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; Empire HealthChoice Assurance; same date; AWLP-129023432
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: HMO
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.): includes HNY
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-129002174

State Tracking #:

2013050123

Company Tracking #:

NY SG OFF-EXCH 0513 ART44

State: New York

Filing Company: Empire HealthChoice HMO, Inc.

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

Product Name: NY SG Off-Exch 0513 - Art44

Project Name/Number: SG Off-Ex 0513 Art 44/SG Off-Ex 0513 Art 44

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 HealthChoice HMO, Inc.	New Product	%	%				%	%

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

State: New York **Filing Company:** Empire HealthChoice HMO, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only
 - HMO
Product Name: NY SG Off-Exch 0513 - Art44
Project Name/Number: SG Off-Ex 0513 Art 44/SG Off-Ex 0513 Art 44

Rate Review Detail

COMPANY:

Company Name: Empire HealthChoice HMO, Inc.
 HHS Issuer Id: 80519
 Product Names: HMO
 Trend Factors:

FORMS:

New Policy Forms: NY_HMO_GA_012014
 Affected Forms:
 Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
 Member Months: 255,800
 Benefit Change: None
 Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

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

REQUESTED RATE:

Projected Earned Premium: 116,000,000.00
 Projected Incurred Claims: 96,000,000.00
 Annual \$: Min: 380.00 Max: 684.00 Avg: 453.00

SERFF Tracking #:

AWLP-129002174

State Tracking #:

2013050123

Company Tracking #:

NY SG OFF-EXCH 0513 ART44

State: New York

Filing Company: Empire HealthChoice HMO, Inc.

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

Product Name: NY SG Off-Exch 0513 - Art44

Project Name/Number: SG Off-Ex 0513 Art 44/SG Off-Ex 0513 Art 44

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 44		New		Total Manual Pages - 44r2.pdf,

**Empire HealthChoice HMO, Inc.
Rate Manual**

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Rate Manual - Description of Benefits

Empire HealthChoice HMO, Inc.
Small Group

Form Numbers: NY_HMO_GA_012014

Index	HIOS Plan Name	INN Deductible	INN Coins.	INN OOP Max	OON Coverage
1	Empire Preferred Guided Access Plus w HSA gsqa	\$1,250	10%	\$6,350	No
2	Empire Healthy New York HMO ggza	\$600	20%	\$4,000	No

Rate Manual

Empire HealthChoice HMO, Inc. Small Group

Quarter 1: January - March 2014

Form Numbers: NY_HMO_GA_012014

Albany (Region 1)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$550.72	\$1,101.44	\$936.22	\$1,569.55
2	Empire Healthy New York HMO ggza	\$460.36	\$920.72	\$782.61	\$1,312.03

Long Island (Region 8)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$544.89	\$1,089.78	\$926.31	\$1,552.94
2	Empire Healthy New York HMO ggza	\$455.48	\$910.96	\$774.32	\$1,298.12

Mid-Hudson (Region 3)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$645.05	\$1,290.10	\$1,096.59	\$1,838.39
2	Empire Healthy New York HMO ggza	\$539.21	\$1,078.42	\$916.66	\$1,536.75

New York City (Region 4)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$603.08	\$1,206.16	\$1,025.24	\$1,718.78
2	Empire Healthy New York HMO ggza	\$504.13	\$1,008.26	\$857.02	\$1,436.77

Upstate (Region 7)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$819.70	\$1,639.40	\$1,393.49	\$2,336.15
2	Empire Healthy New York HMO ggza	\$685.20	\$1,370.40	\$1,164.84	\$1,952.82

Rate Manual

Empire HealthChoice HMO, Inc. Small Group

Quarter 2: April - June 2014

Form Numbers: NY_HMO_GA_012014

Albany (Region 1)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$566.15	\$1,132.30	\$962.46	\$1,613.53
2	Empire Healthy New York HMO ggza	\$473.25	\$946.50	\$804.53	\$1,348.76

Long Island (Region 8)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$560.14	\$1,120.28	\$952.24	\$1,596.40
2	Empire Healthy New York HMO ggza	\$468.24	\$936.48	\$796.01	\$1,334.48

Mid-Hudson (Region 3)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$663.11	\$1,326.22	\$1,127.29	\$1,889.86
2	Empire Healthy New York HMO ggza	\$554.31	\$1,108.62	\$942.33	\$1,579.78

New York City (Region 4)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$619.97	\$1,239.94	\$1,053.95	\$1,766.91
2	Empire Healthy New York HMO ggza	\$518.25	\$1,036.50	\$881.03	\$1,477.01

Upstate (Region 7)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$842.65	\$1,685.30	\$1,432.51	\$2,401.55
2	Empire Healthy New York HMO ggza	\$704.39	\$1,408.78	\$1,197.46	\$2,007.51

Rate Manual

Empire HealthChoice HMO, Inc. Small Group

Quarter 3: July - September 2014

Form Numbers: NY_HMO_GA_012014

Albany (Region 1)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$582.01	\$1,164.02	\$989.42	\$1,658.73
2	Empire Healthy New York HMO ggza	\$486.51	\$973.02	\$827.07	\$1,386.55

Long Island (Region 8)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$575.84	\$1,151.68	\$978.93	\$1,641.14
2	Empire Healthy New York HMO ggza	\$481.36	\$962.72	\$818.31	\$1,371.88

Mid-Hudson (Region 3)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$681.69	\$1,363.38	\$1,158.87	\$1,942.82
2	Empire Healthy New York HMO ggza	\$569.84	\$1,139.68	\$968.73	\$1,624.04

New York City (Region 4)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$637.34	\$1,274.68	\$1,083.48	\$1,816.42
2	Empire Healthy New York HMO ggza	\$532.77	\$1,065.54	\$905.71	\$1,518.39

Upstate (Region 7)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$866.25	\$1,732.50	\$1,472.63	\$2,468.81
2	Empire Healthy New York HMO ggza	\$724.12	\$1,448.24	\$1,231.00	\$2,063.74

Rate Manual

Empire HealthChoice HMO, Inc. Small Group

Quarter 4: October - December 2014

Form Numbers: NY_HMO_GA_012014

Albany (Region 1)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$598.31	\$1,196.62	\$1,017.13	\$1,705.18
2	Empire Healthy New York HMO ggza	\$500.14	\$1,000.28	\$850.24	\$1,425.40

Long Island (Region 8)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$591.97	\$1,183.94	\$1,006.35	\$1,687.11
2	Empire Healthy New York HMO ggza	\$494.84	\$989.68	\$841.23	\$1,410.29

Mid-Hudson (Region 3)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$700.78	\$1,401.56	\$1,191.33	\$1,997.22
2	Empire Healthy New York HMO ggza	\$585.80	\$1,171.60	\$995.86	\$1,669.53

New York City (Region 4)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$655.19	\$1,310.38	\$1,113.82	\$1,867.29
2	Empire Healthy New York HMO ggza	\$547.69	\$1,095.38	\$931.07	\$1,560.92

Upstate (Region 7)

Index	HIOS Plan Name	Individual	Husband/ Wife	Parent/ Child(ren)	Family
1	Empire Preferred Guided Access Plus w HSA gsqa	\$890.52	\$1,781.04	\$1,513.88	\$2,537.98
2	Empire Healthy New York HMO ggza	\$744.40	\$1,488.80	\$1,265.48	\$2,121.54

Empire HealthChoice HMO, 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										
GOLD														
Empire Preferred Guided Access Plus HMO with H.S.A. (gsqa)	\$1250/\$2500	ded/coins	ded/coins	ded/coins	10%	\$6,350/ \$12,700	Ded/10%	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins	ded/coins
Healthy New York HMO	\$600	\$25	\$40	\$15	20%	\$4,000/ \$8,000	\$10/\$35/\$70	\$1000 per admission	\$150	\$60	\$100	\$1000 per admission	PCP copay per visit	PT/OT/ST copay per visit

Rate Manual

Empire HealthChoice HMO, 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 29-44	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-44	\$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 HMO, 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 HMO, Inc

Rate Manual

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RX-SOB-3T-44-SG; RX-NOC-44.Rev1011	III-1 - III-4

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

Review Standards for

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

Instructions for SERFF Checklist:

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

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		(If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, 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 	

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

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		<p>approval by the Department. §52.32(a)(3)</p> <ul style="list-style-type: none"> That if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval. §52.32(a)(4) <p><i>Note: At the time the insurer agrees to provide insurance, it cannot have been reasonably possible to obtain approval prior to the effective date of coverage because the group requested the insurer provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the insurer agrees to provide insurance. § 52.32(c). Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.</i></p>	
<p>Statement of ERISA rights</p> <p>Is the insurer providing document as the plan administrator or for the plan administrator? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)</p>	<p>Plan administrators of an employee benefit plan are required to furnish a copy of a Statement of ERISA rights as provided for in 29 CFR § 2520.102-3(t). If the insurer is providing this document as the plan administrator, or for the plan administrator, please indicate in the adjacent box.</p>	
<p>APPLICATION FORMS</p> <p>Model Application Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>		<p>Form/Page/Para Reference</p>
<p>Authorization</p>	<p>11 NYCRR 420.18(b)</p>	<p>If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.</p>	<p>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>	

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		<p>A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? Yes No</p> <p>B. If you answered “yes”, please provide the name of the company issuing the stand-alone dental coverage. _____ If you answered “no”, we will provide you coverage of the pediatric dental essential health benefit.</p>	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	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

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<p>Provider (PCP) & Access to Pediatrics</p> <p>Does this product require a PCP to be designated? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language</p>	<p>form permits an insured to designate any participating PCP who is available to accept the insured.</p> <p>If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.</p>	
<p>Direct Access to OB/GYN Services</p> <p>Does this product require a PCP to be designated? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language</p>	<p>If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that:</p> <ul style="list-style-type: none"> • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer. 	<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>

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		insured can obtain such referral.	
Specialty Care Provider as PCP Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured’s medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	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

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		non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	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

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<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 29-43</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>

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		on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners	§4235(f)(1)(A) §4305(c)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: <ul style="list-style-type: none"> • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	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

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		<p>limitations; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance, as well as DFS review.</p> <p>The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative</p>	
PREVENTIVE CARE			
<p>Primary and Preventive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(l)(8) §3221(k)(18) §4303(j) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100</p>	<p>This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19:</p> <ul style="list-style-type: none"> • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p>	<p>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>

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines</p>	<ul style="list-style-type: none"> • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p>	
<p>Family Planning & Reproductive Health Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines</p>	<p>This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.</p> <p>This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>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 	

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		<ul style="list-style-type: none"> An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	
EMERGENCY SERVICES AND URGENT CARE			
<p>Pre-Hospital Emergency Medical and Ambulance Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(15) § 4303(aa) Model Language</p>	<p><u>Emergency Medical and Ambulance Services:</u> This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person’s bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person.</p> <p>An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization.</p> <p><u>Non-Emergency Ambulance Services:</u> This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:</p> <ul style="list-style-type: none"> From a Non-Participating Hospital to a Participating Hospital. To a Hospital that provides a higher level of care that was not available at the original Hospital. To a more cost-effective acute care facility. From an acute facility to a sub-acute setting. 	page 23
<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 	page 26

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

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Model Language	scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	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

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

Benefit explanation:

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<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>

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		cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	
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

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

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Circular Letter No. 29 (1979) Model Language</p>	<p>Such coverage may not be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Second Opinion in Other Cases Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider’s recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>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>

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Cancer Rights Act of 1998, 29 USC 1185(b) Model Language</p>	<p>symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.</p>	
<p>Transplants Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>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>

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		<p>The policy or contract form shall include a definition of “assistive communication devices” which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	
<p>Diabetes Equipment, Supplies and Self-Management Education</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(k)(7) §4303(u) 10NYCRR60-3.1 Model Language</p>	<p>This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3221(k)(7) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits.</p> <p><i>Note: Plans may apply either a medical or a prescription benefit depending upon whichever will provide a more generous benefit.</i></p> <p><i>Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy or contract form may not limit coverage to care prescribed by a physician.</i></p>	<p>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>

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		<p>malfunctions. <i>{Drafting Note: The limit on hearing aids is required for plans but this limit may be removed or modified so that coverage is more favorable.}</i></p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Hospice Care</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(d)(10) §4303(o) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member’s immediate family cope with the emotional and social issues related to the Member’s death.</p> <p>Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits.</p> <p><i>Note: A plan must cover 210 days of hospice care; however plans can cover more than 210 days.</i></p>	<p>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>

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<p>Hospital Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.5 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including:</p> <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>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>

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		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	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

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

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<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>

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		<p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member’s own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p> <p><i>Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
PRESCRIPTION DRUGS			
<p>Prescription Drugs</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription” so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the same number of prescription drugs in each category and class as the benchmark plan.</p> <p>This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<p>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>

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		diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Off-Label Cancer Drug Usage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(l)(12) §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard’s Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	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

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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		must be provided with no cost-sharing. <i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law...", the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.</i>	
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input 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

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<p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p>preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	<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 as guaranteed availability, rating tiers, rating regions, etc. For rating purposes, the pediatric dental benefit would be included in the insurer's single risk pool, medical loss ratio calculations and actuarial value calculations. Expenses related to an embedded pediatric dental benefit must also be included as part of the calculation of deductibles and out of pocket expense maximums.</i></p> <p><i>If the insurer offers a bundled stand-alone pediatric dental benefit, the following conditions must all be met:</i></p> <ul style="list-style-type: none"> • <i>The bundled dental benefit is identical to a stand-alone dental plan offered by the same dental carrier that is certified by the Exchange but offered outside the Exchange, including at the same premiums;</i> • <i>The policyholder or contractholder is informed that the dental benefit is being offered by a separate insurer, even if only one issuer collects the premiums;</i> • <i>The policyholder or contractholder is clearly informed of the medical plan design and the dental plan design and that the two plan designs have different deductibles, cost sharing and OOP maximums;</i> • <i>The policyholder or contractholder is clearly informed that they can purchase any stand-alone dental plan, other than the bundled dental plan, that has been certified by the Exchange but offered outside the Exchange.</i> • <i>The pediatric dental benefit meets the 70% or 85% actuarial value and \$700 OOP maximum for one covered child (or \$1,400 if more than one child in the family is covered);</i> 	<p>page 60</p>

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

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Acupuncture		This policy or contract form provides coverage for acupuncture.	
MAKE AVAILABLE BENEFITS			
Care in a Nursing Home or Skilled Nursing Facility	§ 3221(1)(2) § 4303(d)	This policy or contract must make available coverage for care in a nursing home, as defined by Public Health Law §2801, or a skilled nursing facility as defined in 42 USC §§1395, when such services are preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.	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	

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>) Model Language	accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	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

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<p>Services Separately Billed by Hospital Employees</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(8)) Model Language</p>	<p>This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.</p>	<p>page 63</p>
<p>Services Provided by a Family Member</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(8)) Model Language</p>	<p>This policy or contract form excludes coverage for 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.</p>	<p>page 63</p>
<p>Services With No Charge</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(8)) Model Language</p>	<p>This policy or contract form excludes coverage for services for which no charge is normally made.</p>	<p>page 63</p>
<p>Services not Listed</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3201(c)(3) Model Language</p>	<p>This policy or contract form excludes coverage for services that are not listed in the policy or contract form as being covered.</p>	<p>page 63</p>
<p>Vision Services</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(10) Model Language</p>	<p>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.</p>	<p>page 63</p>
<p>Workers' Compensation</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(8)) Model Language</p>	<p>This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.</p>	<p>page 63</p>
<p>War</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11NYCRR52.16(c)(4)(i) Model Language</p>	<p>This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.</p>	<p>page 64</p>
<p>CLAIM DETERMINATION</p>			<p>Form/Page/Para Reference</p>
<p>Notice of Claim</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(a)(8) Model Language</p>	<p>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.</p>	<p>page 65</p>
<p>Submission of Claim</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§3221(a)(9) §4305(m) Model Language</p>	<p>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.</p>	<p>page 65</p>

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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>

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<p>COORDINATION OF BENEFITS</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.23 Model Language</p>	<p>If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.</p>	<p>Form/Page/Para Reference</p>
<p>TERMINATION OF COVERAGE</p> <p>Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p><i>The following are the only termination provisions permissible under the Insurance Law.</i></p>	<p>Form/Page/Para Reference</p>
<p>Notice of Termination</p>	<p>11 NYCRR 52.18(c)</p>	<p>Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.</p>	<p>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>

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Termination upon death of Subscriber		This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	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

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		<p>The continuation benefits terminate:</p> <ul style="list-style-type: none"> • 36 months after the date the employee or member’s benefits would otherwise have terminated because of termination of employment or membership. • In the case of an eligible dependent, 36 months after the date such person’s benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy or contract. • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage. • The end of the period for which premiums were made if the employee or member fails to make timely payment. 	
<p>Young Adult Option</p> <p>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</p> <p>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>

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Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Conversion - Right to a New Contract After Termination Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	§3221(e) §4303(d)	<p>This policy or contract form provides that if the employee under the group contract ceases to be covered because of termination of coverage because of: (1) termination for any reason of his employment, or (2) termination for any reason whatsoever of the group policy or contract itself, unless the group policy or contract holder has replaced the group policy or contract with similar and continuous coverage for the same group, such employee shall be entitled to a new policy or contract as a direct pay member, covering such member and his eligible dependents.</p> <p>Conversion must also be made available, upon the death of the employee, to the surviving spouse and dependents, and the former spouse of the employee upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract or whose young adult coverage terminates.</p> <p>The policy or contract form provides that the employee or his eligible dependents must request conversion within sixty days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. The employee or his eligible dependents must also pay the first premium of the new contract at the time they apply for coverage.</p> <p>Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.</p>	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

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	Model Language		
Unilateral Modification Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	11NYCRR52.18(a)(8) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the group. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the group to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such group no less than 14 days prior to the date by which the group is required to provide notice to terminate coverage.	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

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<p>Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract <input type="checkbox"/> Rider <input type="checkbox"/></p>			
<p>Extended Dependent Coverage Model Language Used? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>§4235(f)(1)(B) §4305(c)(1) Model Language</p>	<p>For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the 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).</p>	<p>See RIDER_Age 29-44</p>
<p>Contraceptive Drugs and Devices and Family Planning Services</p>	<p>§3221(l)(16)</p>	<p>This policy or contract form includes a rider for situations when a Group has elected not to purchase coverage for contraceptive drugs or devices pursuant to the religious employer exemption pursuant to §§3221(l)(16)(A); 4303(cc)(1)(A). In accordance with law, if elected by an insured, this Rider amends the policy or contract and provides coverage for contraceptive drugs or devices or generic equivalents approved as substitutes by the federal food and drug administration and provides coverage for family planning services.</p>	<p>see RIDER_WPS-44</p>
<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: Network ID #: Date Submitted: Date Approved:</p>	<p>§3201(c)</p>	<p>If the insurance (other than HMO) policy or contract will be used in conjunction with a provider network, please identify in the adjacent box whether the insurer is using the same network that was submitted to and/or approved by the Department of Health and/or the Exchange. Please indicate the network name and network ID number and include the date that the network was submitted to and/or approved by the Department of Health and/or the Exchange.</p> <p>If the network differs in any respect from that which was submitted to and/or approved by the Department of Health and/or the Exchange, please provide details on how the network differs in the Supporting Documentation Tab in SERFF. This includes, but is not limited to, detailing the providers and specialty types in each county that differ from the network that was submitted to and/or approved by the Department of Health and/or the Exchange .</p> <p>In addition, the following items or information must be submitted as part of this filing:</p> <ul style="list-style-type: none"> • Participating provider directory; • Whether the provider network is capitated; • Provider selection criteria; • Quality assurance procedures; • Breakdown of geographic service area by county; • The underlying assumptions for the network regarding ratios of providers to insureds, the travel times and distances to participating providers; • Sample participating provider agreement; and, • Listing of providers by specialty type by county. <p><i>Note: The Department will not permit more than a 30% differential between in-network and out-of-</i></p>	

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		<i>network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i>	
ACTUARIAL SECTION FOR <u>NEW PRODUCT</u> RATE FILINGS ONLY		<p>PLEASE NOTE: A new and detailed set of instructions “Instructions for the Submission of 2014 Premium Rates for SHOP On-Exchange Plans and Off-Exchange Plans” has been posted on the Department website and on SERFF.</p> <p><i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i> <p><i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i></p>	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	<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"/> %.	

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

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

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

A. Option Selected.

- 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.
- 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated on the attached page(s).

B. Test Option Selected

- 1. Test was applied to the entire policy form(s).
- 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of forms(s) enclosed indicating word samples tested.

C. Standards of Certification (A checked block indicates the standard has been achieved.)

- 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.
- 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables.)
- 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
- 4. The section titles are captioned in bold face or otherwise stand out, significantly from the text.
- 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs, or constructions are not used in the policy.
- 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to an endorsements or riders.
- 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)
- 8.

 _____ Assistant Secretary _____
Officer's Name Officer's Title

DATE: May 15, 2013

Empire HealthChoice HMO, Inc.

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

Form #	Sentences	Words	Syllables	Flesch	Score
G_NY_HMO_R3G6- HSA_GA_B_012014		9 3209	2.0	24.1	
7.G_NY_HMO-HNY_012014 9		3209	2.0	24.1	
NY_HMO_GA_012014 1354		35422	1.68	42.7	
NY_HMO-HNY_GA_012014 1330		34804	1.67	32.8	
NY_GRP CONT-44	222	5536	1.62	46.4	
RIDER_WPS-44 16		310	1.7	43	
RIDER_Age 29-44	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

NY_HMO-HNY_GA_012014 (Healthy New York plan-Standard Gold)

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 (Healthy New York plan-Standard Gold)

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 (variability does not apply to Healthy New York since Pediatric Dental is standard benefit in Standard Gold Plan):** 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.

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 HMO, Inc.
State:	New York
HIOS Issuer ID:	80519
Market:	Small Group
Effective Date:	January 1, 2014

- Company Contact Information

Primary Contact Name:	JoDee Lymburner
Primary Contact Telephone Number:	(212) 476-3698
Primary Contact Email Address:	Jodee.Lymburner@Empireblue.com

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_HMO_GA_012013
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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, Michael Bears, FSA, MAAA, 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 Signature]

[Redacted] FSA, MAAA
Regional Vice President and Actuary III

May 13, 2013

Date

Exhibit A - Base Rate Development

Effective January 1, 2014

**Empire HealthChoice HMO, Inc.
Individual**

	<u>Paid Claims</u>		
1) Experience Period Cost PMPM	\$ 404.78		Exhibit B
2) x <u>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) x <u>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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 and 332 Assessment		2.99%
Federal/State Taxes		1.02%
Profit (Post-Tax)		1.98%
Total	\$40.53	8.54%

Exhibit H - Quality Improvement/Cost Containment Programs

Empire HealthChoice HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, Inc. Small Group

Group Name: Sample Group
Effective Date: 01/01/2014
On/Off Exchange: Off
Metal Level: Gold
Plan ID: 80519NY0200001
Rating Area: Albany
Network: Narrow
Group Census:

Calculation of Monthly Premium:

Base Rate =	\$	542.90	Exhibit A
x Benefit Plan Factor		1.0751	Exhibit J
<u>x Area Factor</u>		<u>0.9435</u>	Exhibit K
Base Rate Adjusted for Plan/Area =	\$	550.69	

Final Monthly Premium PMPM:

<u>Contract Type</u>	<u>Family Composition Factor (Exhibit L)</u>	<u>Monthly Rate</u>
Single	1.00	\$ 550.69
Single + Spouse	2.00	\$ 1,101.38
Single + Child(ren)	1.70	\$ 936.17
Single + Spouse + Child(ren)	2.85	\$ 1,569.47

Exhibit O - Federal MLR Estimated Calculation

Empire HealthChoice HMO, 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	\$4.63	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>	\$417.91	

Estimated Federal MLR

88.84%

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 HMO, 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 HMO, Inc. Small Group

	Weighted Average for Risk Pool	
	<u> </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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 Preferred Guided Access Plus w HSA gsqa	\$427.52	1.0964	1.1147	1.2195	\$390.79	1.0276	1.0008	\$401.88
Empire Healthy New York HMO ggza	\$427.52	1.1527	1.1710	1.2195	\$410.54	0.8173	1.0012	\$335.94

{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 HMO, 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:
	a) Administrative Costs, excluding Profits	b) Profit/Contribution to Surplus Margins	c) Total Administrative Expense Load: (11)(a) + (11)(b)	(10) ÷ [1 - (11)(c)]
Empire Preferred Guided Access Plus w HSA gsqa	14.49%	3.00%	17.49%	\$487.05
Empire Healthy New York HMO ggza	14.49%	3.00%	17.49%	\$407.13

{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 HMO, 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 Preferred Guided Access Plus w HSA gsqa	1.199	\$583.73	\$583.73	\$1,167.46	\$992.34	\$1,459.33
Empire Healthy New York HMO ggza	1.199	\$487.95	\$487.95	\$975.90	\$829.52	\$1,219.88

{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 HMO, Inc.
State:	New York
HIOS Issuer ID:	80519
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_HMO_GA_012013
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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 HMO, Inc.
Individual**

	<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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 and 332 Assessment		2.99%
Federal/State Taxes		1.02%
Profit (Post-Tax)		1.98%
Total	\$40.53	8.54%

Exhibit H - Quality Improvement/Cost Containment Programs

Empire HealthChoice HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, Inc. Small Group

Group Name: Sample Group
Effective Date: 01/01/2014
On/Off Exchange: Off
Metal Level: Gold
Plan ID: 80519NY0200001
Rating Area: Albany
Network: Narrow
Group Census:

Calculation of Monthly Premium:

Base Rate =	\$	542.90	Exhibit A
x Benefit Plan Factor		1.0751	Exhibit J
<u>x Area Factor</u>		<u>0.9435</u>	Exhibit K
Base Rate Adjusted for Plan/Area =	\$	550.69	

Final Monthly Premium PMPM:

<u>Contract Type</u>	<u>Family Composition Factor (Exhibit L)</u>	<u>Monthly Rate</u>
Single	1.00	\$ 550.69
Single + Spouse	2.00	\$ 1,101.38
Single + Child(ren)	1.70	\$ 936.17
Single + Spouse + Child(ren)	2.85	\$ 1,569.47

Exhibit O - Federal MLR Estimated Calculation

Empire HealthChoice HMO, 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	\$4.63	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>	\$417.91	

Estimated Federal MLR

88.84%

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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 Preferred Guided Access Plus w HSA gsqa	\$427.52	1.0964	1.1147	1.2195	\$390.79	1.0276	1.0008	\$401.88
Empire Healthy New York HMO ggza	\$427.52	1.1527	1.1710	1.2195	\$410.54	0.8173	1.0012	\$335.94

{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 HMO, 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:
	a) Administrative Costs, excluding Profits	b) Profit/Contribution to Surplus Margins	c) Total Administrative Expense Load: (11)(a) + (11)(b)	(10) ÷ [1 - (11)(c)]
Empire Preferred Guided Access Plus w HSA gsqa	14.49%	3.00%	17.49%	\$487.05
Empire Healthy New York HMO ggza	14.49%	3.00%	17.49%	\$407.13

{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 HMO, 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 Preferred Guided Access Plus w HSA gsqa	1.199	\$583.73	\$583.73	\$1,167.46	\$992.34	\$1,459.33
Empire Healthy New York HMO ggza	1.199	\$487.95	\$487.95	\$975.90	\$829.52	\$1,219.88

{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.

User Inputs for Plan Parameters

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

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	70%
		2nd Tier Utilization:	30%

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

Tier 2 Plan Benefit Design			
	Medical	Drug	Combined
			\$6,000.00
			100.00%
			\$6,400.00

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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 type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	70%	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
Non-Preventive Well Baby Visits and Care							100%	
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	96.12%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	93.22%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<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: 79.0%
 Metal Tier: Gold
 \$4,271.05
 \$5,403.01

User Inputs for Plan Parameters

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

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

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$1,250.00			\$500.00
Coinsurance (% , Insurer's Cost Share)			90.00%			80.00%
OOP Maximum (\$)			\$6,350.00			\$15,000.00
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 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: 78.4%
 Metal Tier: Gold
 \$4,233.73
 \$5,403.01

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A.	Insurer Information: <u>Empire HealthChoice HMO, Inc.</u> <small>Company submitting the rate adjustment request</small>	<u>HMO - 44</u> <small>Company Type</small>	<u>For Profit</u> <small>Org. Type</small>	<u>95433</u> <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): <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-129002174</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: <u>Empire HealthChoice HMO, Inc.</u> <small>Company submitting the rate adjustment request</small>	<u>HMO - 44</u> <small>Company Type</small>	<u>For Profit</u> <small>Org. Type</small>	<u>95433</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: [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): <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-129002174</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 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 HMO Inc.
 NAIC Code: 95433
 SERFF Number: AWLP-129002174
 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
- 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	
C IPA-1	Small Group HMO	Direct HMO /	SG HMO	1/1/2014	SG	HMO	Yes	Open	4,453	15,396	XX
G-HMO-IN with	Direct POS	Direct POS	SG POS 1	1/1/2014	SG	HMO based POS	Yes	Closed	N/A	N/A	XX
CERT-44; HNY HMO-CERT	Healthy New York	Healthy New York	HNY	1/1/2014	HNY-SG	HMO	No	Open	3,908	15,846	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 Healthy 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) (\$)	
C IPA-1	Small Group HMO	Direct HMO /	11/01/11	10/31/12	237,014	123,257,208	148,984,194	125,489,050	116,685,869	0	(343,690)	10,470,490	XX
G-HMO-IN with	Direct POS	Direct POS	11/01/11	10/31/12	41,713	27,481,275	N/A	28,647,020	24,618,157	0	(57,427)	2,393,911	XX
CERT-44; HNY HMO-CERT	Healthy New York	Healthy New York	11/01/11	10/31/12	213,895	69,832,606	70,551,127	68,638,803	65,393,570	(3,835,495)	0	6,150,296	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) (\$)	
C IPA-1	Small Group HMO	Direct HMO /	11/01/10	10/31/11	429,812	200,699,691	281,845,386	197,423,193	197,423,193	0	(2,007,114)	16,933,830	XX
G-HMO-IN with	Direct POS	Direct POS	11/01/10	10/31/11	102,895	64,180,555	N/A	42,617,455	42,617,455	0	(2,408,870)	5,600,939	XX
CERT-44; HNY HMO-CERT	Healthy New York	Healthy New York	11/01/10	10/31/11	234,250	66,171,932	79,000,813	59,467,674	59,467,674	(22,555,778)	0	5,685,461	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) (\$)
C IPA-1	Small Group HMO	Direct HMO /	11/01/09	10/31/10	675,913	303,226,956	485,734,129	285,840,340	267,749,100	0	1,285,286	33,863,906
G-HMO-IN with	Direct POS	Direct POS	11/01/09	10/31/10	104,264	60,199,844	N/A	53,784,974	54,674,082	0	-1,490,725	5,982,769
CERT-44; HNY HMO-CERT	Healthy New York	Healthy New York	11/01/09	10/31/10	210,107	57,633,137	72,638,192	51,935,593	49,909,558	(24,700,874)	0	5,777,942

Exhibit 8 - Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Empire HealthChoice HMO, Inc.

NAIC Code: 95433

SERFF Number: AWLP-129002174

Market Segment: Small Group

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

Line #	General	HMO QHP Off Exchange	Healthy New York	HMO QHP Off Exchange	Healthy New York
1	Product*				
2	Product ID*	80519NY020	80519NY008	80519NY020	80519NY008
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7836	0.7900	0.7836	0.7900
5	AV Pricing Value (total, risk pool experience based)*	1.1856	0.9910	1.1856	0.9910
6	Plan Type*	HMO	HMO	HMO	HMO
7	Plan Name*	Empire Preferred Guided Access Plus w HSA gsqa	Empire Healthy New York HMO ggza	Empire Preferred Guided Access Plus w HSA gsqa	Empire Healthy New York HMO ggza
8	Plan ID*	80519NY0200001	80519NY0080001	80519NY0200002	80519NY0080002
9	Exchange Plan?*	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	330.79	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	by rating regions ** by the standard rating regions	1.000			
20	(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	1.060	1.060	1.060

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	1.015	1.067	1.015	1.067
29	Pricing actuarial value (only the induced demand factor) #	1.080	1.080	1.080	1.080
30	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)	1.009	1.000	1.009	1.000
34	Administrative costs (excluding Exchange user fees and profits)	1.176	1.176	1.176	1.176
35	Profit/Contribution to surplus margins	1.031	1.031	1.031	1.031
36	Impact of eligibility categories (catastrophic plans only)	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
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	0.800	1.000	0.800
39	Other 1 (Pediatric Dental, Pediatric Vision and Gym Membership)	1.017	1.016	1.017	1.016
40	Other 2 (Covered Lives Assessment and Rounding Adjustment)	1.019	1.023	1.019	1.023
41	Impact of Plan Level Adjustments (product L28 through L40)	1.389	1.161	1.389	1.161

Changes that affect an entire standard population as cost sharing

c 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)	487.05	407.13	487.05	407.13
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EXHIBIT 9: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES INCLUDED IN CURRENT FILING

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

Company Name: Empire HealthChoice HMO, Inc.
NAIC Code: 95433
SERFF Number: AWLP-129002174
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
Gold	Off Exchange	Empire Preferred Guided Access Plus w HSA gsqa	02/01/14	01/31/15	11.09%	0.99%	0.58%	1.91%	2.00%	2.61%	6.40%	14.49%	1.98%	0.00%
Gold	Off Exchange	Empire Healthy New York HMO ggza	02/01/14	01/31/15	11.09%	0.99%	0.58%	1.91%	2.00%	2.61%	6.40%	14.49%	1.98%	0.00%

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

ICATION

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10
Gold	Off Exchange	Empire Preferred Guided Access Plus w HSA gsqa	0.00%	1.02%	34.08%	0.00%	17.49%
Gold	Off Exchange	Empire Healthy New York HMO ggza	0.00%	1.02%	34.08%	0.00%	17.49%

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

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	12.3 Commissions and broker fees - as \$mpm	12.4 Premium Taxes - as \$mpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm	12.6 Other administrative expenses - as \$mpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as \$mpm	14. State income tax component - as \$mpm	15. Federal income tax component - as \$mpm	16. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Gold	Off Exchange	Empire Preferred Guided Access Plus w HSA gsqa	4.82	2.81	9.31	9.74	12.69	31.19	70.56	9.64	0.00	4.97	0.00	85.17
Gold	Off Exchange	Empire Healthy New York HMO ggza	4.03	2.35	7.78	8.14	10.61	26.07	58.98	8.06	0.00	4.15	0.00	71.19

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Empire HealthChoice HMO, Inc.
State:	New York
HIOS Issuer ID:	80519
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_HMO_GA_012013
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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 HMO, Inc.
Individual**

	<u>Paid Claims</u>		
1) Experience Period Cost PMPM	\$ 404.78		Exhibit B
2) x <u>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) x <u>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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 and 332 Assessment		2.99%
Federal/State Taxes		1.02%
Profit (Post-Tax)		1.98%
Total	\$40.53	8.54%

Exhibit H - Quality Improvement/Cost Containment Programs

Empire HealthChoice HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, Inc. Small Group

Group Name: Sample Group
Effective Date: 01/01/2014
On/Off Exchange: Off
Metal Level: Gold
Plan ID: 80519NY0200001
Rating Area: Albany
Network: Narrow
Group Census:

Calculation of Monthly Premium:

Base Rate =	\$	542.90	Exhibit A
x Benefit Plan Factor		1.0751	Exhibit J
<u>x Area Factor</u>		<u>0.9435</u>	Exhibit K
Base Rate Adjusted for Plan/Area =	\$	550.69	

Final Monthly Premium PMPM:

<u>Contract Type</u>	<u>Family Composition Factor (Exhibit L)</u>	<u>Monthly Rate</u>
Single	1.00	\$ 550.69
Single + Spouse	2.00	\$ 1,101.38
Single + Child(ren)	1.70	\$ 936.17
Single + Spouse + Child(ren)	2.85	\$ 1,569.47

Exhibit O - Federal MLR Estimated Calculation

Empire HealthChoice HMO, 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	\$4.63	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>	\$417.91	

Estimated Federal MLR

88.84%

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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 HMO, 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 Preferred Guided Access Plus w HSA gsqa	\$427.52	1.0964	1.1147	1.2195	\$390.79	1.0276	1.0008	\$401.88
Empire Healthy New York HMO ggza	\$427.52	1.1527	1.1710	1.2195	\$410.54	0.8173	1.0012	\$335.94

{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 HMO, 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:
	a) Administrative Costs, excluding Profits	b) Profit/Contribution to Surplus Margins	c) Total Administrative Expense Load: (11)(a) + (11)(b)	(10) ÷ [1 - (11)(c)]
Empire Preferred Guided Access Plus w HSA gsqa	14.49%	3.00%	17.49%	\$487.05
Empire Healthy New York HMO ggza	14.49%	3.00%	17.49%	\$407.13

{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 URRRT.

{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 HMO, 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 Preferred Guided Access Plus w HSA gsqa	1.199	\$583.73	\$583.73	\$1,167.46	\$992.34	\$1,459.33
Empire Healthy New York HMO ggza	1.199	\$487.95	\$487.95	\$975.90	\$829.52	\$1,219.88

{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.

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A.	Insurer Information: <u>Empire HealthChoice HMO, Inc.</u> <small>Company submitting the rate adjustment request</small>	<u>HMO - 44</u> <small>Company Type</small>	<u>For Profit</u> <small>Org. Type</small>	<u>95433</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: [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): <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-129002174</u> <small>SERFF Tracking Number</small>	
E.	Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement): <u>Small Group</u>			

	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).	<u>No</u>
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	<u>No</u>
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).	<u>No</u>
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?	<u>Yes, all required exhibits have been submitted.</u>
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.	<u>No</u>

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.

SECTION XIV. SCHEDULE OF BENEFITS

[Empire Preferred Guided Access HMO with HSA [gsga]]
 [Gold]
 [Group Name]

COST-SHARING	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	
Deductible <ul style="list-style-type: none"> • Individual • Family Out-of-Pocket Limit <ul style="list-style-type: none"> • Individual • Family 	\$1250 \$2500 \$6350 \$12700	Non-Participating Provider services are not Covered except as required for Emergency Care and Urgent Care.	
OFFICE VISITS	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Medications Administered in Office	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Specialist Office Visits (or Home Visits)	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Medications Administered in Office	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Referral Required			
PREVENTIVE CARE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the	See Benefit For Description

<ul style="list-style-type: none"> • Adult Annual Physical Examinations* 	Covered in full	Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • Adult Immunizations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • Mammography Screenings* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • [Sterilization Procedures for Women* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]
<ul style="list-style-type: none"> • [Vasectomy 	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]
<ul style="list-style-type: none"> • Bone Density Testing* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • Screening for Prostate Cancer 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • All other preventive services required by 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the

USPSTF and HRSA. <ul style="list-style-type: none"> *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. Referral Required	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
EMERGENCY CARE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services Preauthorization Required for Air and Sea Ambulance	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Emergency Department Coinsurance waived if Hospital admission.	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See Benefit For Description
Urgent Care Center Preauthorization Required for Out-of-Network in Service Area	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting 	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services Preauthorization Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Allergy Testing & Treatment Referral Required	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Ambulatory Surgical Center Facility Fee	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefits For Description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services Referral Required	10% Coinsurance after Deductible 10% Coinsurance after Deductible Included As Part of Inpatient Hospital Service Cost-Sharing	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefits For Description
Chemotherapy			See Benefit For

<ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <p>Referral Required</p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>Description</p>
<p>Chiropractic Services</p> <p>Referral Required</p>	<p>10% Coinsurance after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <p>Referral Required</p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Dialysis</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Center or 	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the</p>	<p>See Benefit For Description</p> <p>[Dialysis Performed by Non-Participating</p>

Specialist Office Setting <ul style="list-style-type: none"> Performed as Outpatient Hospital Services Referral Required	10% Coinsurance after Deductible	Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Providers is Limited to [10] Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) Preauthorization; Referral Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 visits per condition, per lifetime combined therapies
Home Health Care Referral Required	10% Coinsurance after \$50 <u>not subject to</u> Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	40 Visits per Plan Year
Infertility Services <u>Preauthorization; Referral Required</u>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Infusion Therapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy 	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description Home Infusion counts towards Home Health

			Care Visit Limits
Inpatient Medical Visits	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Laboratory Procedures <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Laboratory Facility or Specialist Office Performed as Outpatient Hospital Services Referral Required	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Maternity & Newborn Care <ul style="list-style-type: none"> Prenatal Care Inpatient Hospital Services and Birthing Center Physician and Nurse Midwife Services for Delivery Breast Pump Preauthorization Required Except for Breast Pump	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible Covered in Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the	See Benefit For Description

		Full Cost	
Preadmission Testing	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <p>Preauthorization Required Except for Standard X-rays and Noncardiac Ultrasound</p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	See Benefit For Description
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <p>Preauthorization Required</p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	See Benefit For Description
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p>Preauthorization; Referral</p>	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 visits per condition, per lifetime combined therapies

Required			Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Retail Health Clinic Referral Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Second Opinions on the Diagnosis of Cancer, Surgery & Other Referral Required	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when a Referral is obtained.	See Benefit For Description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants) <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery 	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services	See Benefit For Description [All Transplants Must be Performed at Designated Facilities]

Preauthorization Required		Are Not Covered and You Pay the Full Cost	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder Preauthorization Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder Preauthorization Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education 	See the Prescription Drug Cost-Sharing 10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Prescription Drug Benefit See Benefit For Description
Durable Medical Equipment & Braces Preauthorization Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
External Hearing Aids Referral Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Single Purchase Once Every 3 Years
Cochlear Implants Preauthorization Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One Per Ear Per Time Covered

Hospice Care • Inpatient	Paid in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	210 Days per Plan Year
• Outpatient	Paid in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	5 Visits for Family Bereavement Counseling
Medical Supplies	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices • External	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One prosthetic device, per limb, per lifetime
• Internal	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Unlimited See Benefit For Description
Preauthorization Required for External Devices, Except Wigs			
INPATIENT SERVICES & FACILITIES	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preauthorization Required			
Observation Stay	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility (Includes	10% Coinsurance after Deductible	Non-Participating Provider Services	[200] [365] Days

Cardiac & Pulmonary Rehabilitation) Preauthorization Required		Are Not Covered and You Pay the Full Cost	Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) Preauthorization Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services – Preauthorization Required)	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Outpatient Substance Use Services Preauthorization Required	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy 30 Day Supply Tier 1 Tier 2 Tier 3	10% Coinsurance Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Mail Order Pharmacy Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
WELLNESS BENEFITS	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$200 per 6 month period for Spouse and eligible Dependents, up to \$1200 annual maximum reimbursement	Up to \$200 per 6 month period; up to an additional \$200 per 6 month period for Spouse and eligible Dependents, up to \$1200 annual maximum reimbursement	See Benefit For Description
[PEDIATRIC DENTAL &]VISION CARE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
[Dental Care • Preventive/ Routine Dental Care	Paid in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One Dental Exam & Cleaning Per 6-Month Period]

<ul style="list-style-type: none"> • Major Dental (Endodontics & Prosthodontics) • Orthodontia 	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>		
<p>Vision Care (under age 19)</p> <ul style="list-style-type: none"> • Routine Eye Exams • Lenses (Single, Bifocal, Trifocal) • Lens Treatments: <ul style="list-style-type: none"> – UV Coating – Standard Factory Scratch Coating – Standard Polycarbonate – Standard Transitions – Standard Progressive Lenses • Frames • Contact Lenses <ul style="list-style-type: none"> – Elective – Non-Elective 	<p>Paid in full not subject to Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period</p>
<p>Vision Care (over age 19)</p> <ul style="list-style-type: none"> • Routine Eye Exams • Lenses <ul style="list-style-type: none"> – Single – Bifocal – Trifocal 	<p>\$20 Copayment not subject to Deductible</p> <p>\$25 Reimbursement</p> <p>\$40 Reimbursement</p> <p>\$55 Reimbursement</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period</p>

<ul style="list-style-type: none"> • Lens Treatments: <ul style="list-style-type: none"> – UV Coating – Standard Factory Scratch Coating – Standard Polycarbonate – Standard Transitions – Standard Progressive Lenses • Frames • Contact Lenses <ul style="list-style-type: none"> – Elective – Non-Elective 	<p>\$15 Discounted member cost Paid in full not subject to Deductible</p> <p>\$40 Discounted member cost</p> <p>\$75 Discounted member cost \$65 Discounted member cost</p> <p>Paid in full, up to \$130 Maximum Allowance, not subject to Deductible</p> <p>Paid in full, up to \$80 Maximum Allowance, not subject to Deductible Paid in full, up to \$80 Maximum Allowance, not subject to Deductible</p>		
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SECTION XIV. SCHEDULE OF BENEFITS

**[Essential Guided Access HMO [gpdf]]
[Gold]
[Group Name]**

COST-SHARING	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Deductible <ul style="list-style-type: none"> • Individual • Family Out-of-Pocket Limit <ul style="list-style-type: none"> • Individual • Family 	\$600 \$1200 \$4000 \$8000	Non-Participating Provider services are not Covered except as required for Emergency Care and Urgent Care.	
OFFICE VISITS	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits) Medications Administered in Office	\$25 Copayment after Deductible \$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Specialist Office Visits (or Home Visits) Medications Administered in Office Referral Required	\$40 Copayment after Deductible \$40 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
PREVENTIVE CARE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<ul style="list-style-type: none"> • Adult Annual Physical Examinations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • Adult Immunizations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • Mammography Screenings* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • [Sterilization Procedures for Women* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]
<ul style="list-style-type: none"> • [Vasectomy 	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]
<ul style="list-style-type: none"> • Bone Density Testing* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • Screening for Prostate Cancer 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost
<ul style="list-style-type: none"> • All other preventive services required by USPSTF and HRSA. 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost

<ul style="list-style-type: none"> *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. 	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
EMERGENCY CARE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment after Deductible	\$150 Copayment after Deductible	See Benefit For Description
Non-Emergency Ambulance Services Preauthorization Required for Air and Sea Ambulance	\$150 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Emergency Department Copayment waived if Hospital admission.	\$150 Copayment after Deductible	\$150 Copayment after Deductible	See Benefit For Description
Urgent Care Center Preauthorization Required for Out-of-Network in Service Area	\$60 Copayment after Deductible	\$60 Copayment after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services 	\$40 Copayment after Deductible \$40 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full	See Benefit For Description

Preauthorization Required		Cost	
Allergy Testing & Treatment Referral Required	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Ambulatory Surgical Center Facility Fee	\$100 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	Covered in full not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefits For Description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services Referral Required	<p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>Included As Part of Inpatient Hospital Service Cost-Sharing</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	See Benefits For Description
Chemotherapy <ul style="list-style-type: none"> • Performed in a PCP Office 	\$25 Copayment after Deductible	Non-Participating Provider Services	See Benefit For Description

<ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services <p>Referral Required</p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	
<p>Chiropractic Services</p> <p>Referral Required</p>	<p>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <p>Referral Required</p>	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Dialysis</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting 	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p> <p>[Dialysis Performed by Non-Participating Providers is</p>

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services Referral Required	\$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Limited to [10] Visits Per Calendar Year]
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) Preauthorization; Referral Required	\$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 visits per condition, per lifetime combined therapies
Home Health Care Referral Required	\$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	40 Visits per Plan Year
Infertility Services Preauthorization; Referral Required	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Infusion Therapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy 	\$25 Copayment after Deductible \$25 Copayment after Deductible \$25 Copayment after Deductible \$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description Home Infusion counts towards Home Health

			Care Visit Limits
Inpatient Medical Visits	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Laboratory Procedures <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Laboratory Facility or Specialist Office Performed as Outpatient Hospital Services Referral Required	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	See Benefit For Description
Maternity & Newborn Care <ul style="list-style-type: none"> Prenatal Care <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Inpatient Hospital Services and Birthing Center Physician and Nurse Midwife Services for Delivery Breast Pump 	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$1000 Copayment per admission after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>Covered in Full</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p> <p>1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>

Preauthorization Required except for Breast Pump		Cost	
Outpatient Hospital Surgery Facility Charge	\$100 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preadmission Testing	Paid in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Diagnostic Radiology Services <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services 	\$25 Copayment after Deductible \$40 Copayment after Deductible \$40 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preauthorization Referral except for Standard X-rays and Noncardiac Ultrasound			
Therapeutic Radiology Services <ul style="list-style-type: none"> • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services 	\$25 Copayment after Deductible \$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preauthorization Required			
Rehabilitation Services (Physical	\$30 Copayment after Deductible	Non-Participating Provider Services	60 visits per

<p>Therapy, Occupational Therapy or Speech Therapy)</p> <p>Preauthorization; Referral Required</p>		<p>Are Not Covered and You Pay the Full Cost</p>	<p>condition, per lifetime combined therapies</p> <p>Speech and Physical Therapy are only Covered following a Hospital stay or surgery.</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery & Other</p> <p>Referral Required</p>	<p>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when a Referral is obtained.</p>	<p>See Benefit For Description</p>
<p>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center 	<p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p> <p>All Transplants Must be Performed at Designated Facilities</p>

<ul style="list-style-type: none"> Specialist Office Surgery Preauthorization; Referral Required	\$40 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder Preauthorization Required	\$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder Preauthorization Required	\$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education <ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education 	\$25 Copayment after Deductible \$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Prescription Drug Benefit See Benefit For Description
Durable Medical Equipment & Braces Preauthorization Required	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
External Hearing Aids Referral Required	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Single Purchase Once Every 3 Years
Cochlear Implants Preauthorization Required	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One Per Ear Per Time Covered
Hospice Care			210 Days per

<ul style="list-style-type: none"> Inpatient Outpatient Required] 	<p>\$1000 Copayment per admission after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>Plan Year</p> <p>5 Visits for Family Bereavement Counseling</p>
Medical Supplies	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices <ul style="list-style-type: none"> External Internal <p>Preauthorization Required for External Devices, Except Wigs</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>One prosthetic device, per limb, per lifetime</p> <p>Unlimited See Benefit For Description</p>
INPATIENT SERVICES & FACILITIES	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	\$1000 Copayment per admission after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Observation Stay Copayment waived if Hospital admission.	\$150 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	\$1000 Copayment per admission after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	[200] [365] Days Per Plan Year

Preauthorization Required			
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	\$1000 Copayment per admission after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 Consecutive Days Per Condition, Per Lifetime
Preauthorization Required			
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$1000 Copayment per admission after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions			
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services – Preauthorization Required)	\$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	\$1000 Copayment per admission after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions			
Outpatient Substance Use Services	\$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family
Preauthorization Required			

			Counseling Limits
PRESCRIPTION DRUGS	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	
Retail Pharmacy			
30 Day Supply Tier 1	\$10 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$35 Copayment after Deductible		
Tier 3	\$70 Copayment after Deductible		
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	\$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$88 Copayment after Deductible		
Tier 3	\$175 Copayment after Deductible		
WELLNESS BENEFITS	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse
PEDIATRIC DENTAL & VISION CARE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care		Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One Dental Exam & Cleaning Per 6-Month Period
• Preventive/ Routine Dental Care	Paid in full after Deductible		
• Major Dental (Endodontics & Prosthodontics)	50% Coinsurance after Deductible		
• Orthodontia	50% Coinsurance after Deductible		

Pediatric Vision Care <ul style="list-style-type: none"> • Exa ms • Lenses & Frames • Contact Lenses 	<p>\$25 Copayment after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period</p>
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[LOGO]

This is Your

**HEALTH MAINTENANCE ORGANIZATION
CERTIFICATE OF COVERAGE**

Issued by Empire HealthChoice HMO, Inc.

[To: Group Contractholder]

This Certificate of Coverage (“Certificate”) explains the benefits available to You under a Group Contract between Empire HealthChoice HMO, Inc. (hereinafter referred to as “We”, “Us”, or “Our”) and the Group Contractholder. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

In-Network Benefits. This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in our [Pathway] Network. Care Covered under this Certificate (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive the benefits under this Certificate, You must contact Your Primary Care Physician before You obtain the services except for services to treat an Emergency or Urgent Condition described in the “Emergency Services” section. Except for care for an Emergency Condition described in the “Definitions” section, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.

[SIGNATURE] [SIGNATURE]
[NAME]
Corporate Secretary

[NAME]
President

Services provided by Empire HealthChoice HMO, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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SECTION I. DEFINITIONS

Defined terms will appear capitalized throughout the Certificate.

Acute: The sudden onset of disease or injury, or a sudden change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the "Cost Sharing Expenses and Allowed Amount" section of this Certificate for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by Empire HealthChoice HMO, Inc., including the Schedule of Benefits and any attached riders.

Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the "Who is Covered" section of this Certificate.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Coinsurance, Copayments, and/or Deductibles.

Cover, Covered or Covered Services: The Medically Necessary services paid for or arranged for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment (DME): Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- is appropriate for use in the home.

Emergency Condition: 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:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination 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 Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency 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 patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; ambulatory surgery Facility; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to article 27-J of the public health law; an institutional Provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other Provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If You receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by

the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”) to provide a chemical abuse treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an Agreement with Us.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; osteopath; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist certified to administer immunizing agents; or any other licensed, registered or certified Health Care Professional under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional’s services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are 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 organization is located.

Hospital: A short term, acute, general Hospital, which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- if located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 U.S.C. § 1395x(k));
- is duly licensed by the agency responsible for licensing such Hospitals; and

- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Medically Necessary: See the "How Your Coverage Works" section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber and Covered Dependents for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. The services of Non-Participating Providers are Covered only for Emergency Services, Urgent Care or when authorized by Us.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us or another Blue Cross and/or Blue Shield plan to provide services to You. A list of Participating Providers and their locations is available on Our website at www.empireblue.com or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the "Schedule of Benefits" section of this Certificate.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and

Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Primary Care Physician: A Participating Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who typically is an internal medicine, family practice or pediatric doctor and who directly provides or coordinates a range of health care services for You.

Provider: A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), licensed Health Care Professional or Facility licensed, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a Participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the “Access to Care and Transitional Care” section of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Maximums, Preauthorization requirements, Referral requirements and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of: the following 28 counties in eastern New York State: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare law; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse[and a domestic partner].

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Urgent Care may be rendered in a Physician's office or Urgent Care Center. Urgent Care rendered by a Non-Participating Provider in Our Service Area must be Preauthorized.

Urgent Care Center: A licensed Facility (except Hospitals) that provides Urgent Care.

Us, We, Our: Empire HealthChoice HMO, Inc. and anyone to whom We legally delegate to perform, on Our behalf, under the Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II. HOW YOUR COVERAGE WORKS

- 1. Your Coverage under this Certificate.** Your employer (referred to as the “Group Contractholder”) has purchased a Group HMO Contract from Us. We will provide the benefits described in this Certificate to members of the Group, that is, to employees of the Group and their Covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.
- 2. Covered Services.** You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:
 - Medically Necessary;
 - Provided by a Participating Provider;
 - Listed as a Covered Service;
 - Not in excess of any benefit limitations described in the “Schedule of Benefits” section of this Certificate; and
 - Received while Your Certificate is in force.

Network Providers

- 1. Participating Providers.** To find out if a Provider is a Participating Provider:
 - Check Your Provider directory, available at Your request.
 - Call Member Services.
 - Visit our website at www.empireblue.com.
- 2. The Role of Primary Care Physicians.** This Certificate has a gatekeeper, usually known as a Primary Care Physician (PCP). You need a written Referral from a PCP before receiving Specialist care. You may select any Participating PCP who is available from the list of PCPs in the [Pathway] Network. Each Member may select a different PCP. Children covered under this Certificate may designate a Participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as your PCP. See the “Access to Care and Transitional Care” section of this Certificate for more information about designating a Specialist.

Your PCP is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Your PCP to a Participating Provider for the following services:

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Outpatient mental health care; and
- Diabetic eye exams from an ophthalmologist.

provided that the Participating Provider discusses the services and treatment plan with Your PCP; agrees to follow Our policies and procedures including any procedures

regarding Referrals or Preauthorization for services other than obstetric and gynecologic services rendered by such Participating Provider; and agrees to provide services pursuant to a treatment plan (if any) approved by Us.

Preauthorization

- 1. Services Subject To Preauthorization.** Our Preauthorization is required before You receive certain Covered Services. You and Your Participating Provider is responsible for requesting Preauthorization.
- 2. Preauthorization/Notification Procedure.** If You seek coverage for services that require Preauthorization or notification, You or Your Participating Provider must call Us at the telephone number on Your ID card.

You or Your Participating Provider must contact Us to request Preauthorization as follows:

- At least two weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then during regular business hours prior to the admission.
- At least two weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in a free standing Ambulatory Surgical Center.
- Within the first three months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

You or Your Participating Provider must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You or Your Participating Provider must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

Medical Necessity

- 1. Medical Management.** The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be

provided.

- 2. Care Must Be Medically Necessary.** We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, “service”) is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of: Your medical records; Our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data; professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; the opinion of Health Care Professionals in the generally-recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

See the “Grievance, Utilization Review and External Appeals” section of this Certificate for Your right to an internal appeal and external appeal of Our determination that a service is not Medically Necessary.

Important Telephone Numbers and Addresses

- **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]

- **OUR WEBSITE**

[www.empireblue.com]

SECTION III. ACCESS TO CARE AND TRANSITIONAL CARE

Referral to a Non-Participating Provider

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider. Your Participating Provider must request prior approval of the Referral to a specific Non-Participating Provider. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, Your Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

When a Specialist Can Be Your Primary Care Physician

If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a Non-Participating Specialist unless We determine that We do not have an appropriate Provider in Our Network. If We approve a Non-Participating Specialist, Covered Services rendered by the Non-Participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

Standing Referral to a Participating Specialist

If You need ongoing specialty care, You may receive a "standing Referral" to a Specialist who is a Participating Provider. This means that You will not need a new Referral from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a "standing Referral." Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing Referral to a Non-Participating Specialist unless We determine that We do not have an appropriate Provider in Our Network. If We approve a standing Referral to a Non-Participating Specialist, Covered Services rendered by the Non-Participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

Specialty Care Center

If You have a life-threatening condition or disease or a degenerative and disabling condition or

disease that requires specialty care over a long period of time, You may request a Referral to a specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such a Referral. Any Referral will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation Your PCP or Specialist and You. We will not approve a Referral to a Non-Participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our Network. If We approve a Referral to a Non-Participating specialty care center, Covered Services rendered by the Non-Participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a Participating specialty care center. You will be responsible only for any applicable In-Network Cost-Sharing.

When Your Provider Leaves the Network

If You are in an ongoing course of treatment when Your Provider leaves Our Network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered services 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 our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

New Members In a Course of Treatment

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to sixty (60) days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered services for up to sixty (60) days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

SECTION IV. COST-SHARE EXPENSES AND ALLOWED AMOUNT

1. Deductible.

[Except where stated otherwise, You must pay the amount in the “Schedule of Benefits” section of this Certificate for Covered Services during each Plan Year before We provide coverage. If You have other than Individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has meet the individual Deductible. However, after Deductible payments for all persons covered under this Certificate total the family Deductible amount in the Schedule of Benefits in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.]

[Except where stated otherwise, You must pay the amount in the “Schedule of Benefits” section of this Certificate for Covered Services during each Plan Year before We provide coverage. If You have other than Individual coverage, You must pay the family Deductible in the Schedule of Benefits for Covered Services under this Certificate during each Plan Year. However, after Deductible payments for any and all persons covered under this Certificate total the family Deductible amount in the Schedule of Benefits in a Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.]

[Prescription Drug Deductible. Except where stated otherwise, You must pay the amount in the “Schedule of Benefits” section of this Certificate for Covered Prescription Drugs during each Plan Year before We provide coverage.]

2. **Copayments.** Except where stated otherwise, [after You have satisfied the annual Deductible as described above,] You must pay the Copayments, or fixed amounts, in the “Schedule of Benefits” section of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.
3. **Coinsurance.** Except where stated otherwise, after You have satisfied the annual Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the “Schedule of Benefits” section of this Certificate.
4. **Out-of-Pocket Limit.** When You have met Your Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the “Schedule of Benefits” section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. [If you have other than Individual coverage, the individual Out-of-Pocket Limit applies to each person covered under this Certificate. Once a person within a family meets the individual Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person.] If other than Individual coverage applies, when members of the same family covered under this Certificate have collectively met the family Out-of-Pocket Limit, We will

provide coverage for 100% of the Allowed Amount for the rest of that Plan Year.

- 5. Allowed Amount.** “Allowed Amount” means the maximum amount we will pay to a Provider for the services or supplies covered under this Certificate, before any applicable Deductible, Copayment, and Coinsurance amounts are subtracted. We determine our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider, or the amount approved by another Host Plan, or the Participating Provider’s charge, if less.

See the “Emergency Services” section of the Certificate for the Allowed Amount for an Emergency Condition.

6. Inter-Plan Programs

A. Out-of-Area Covered Healthcare Services

Empire has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of Empire’s Service Area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside Empire’s Service Area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating healthcare providers. Empire’s payment practices in both instances are described below.

Empire covers only limited healthcare services received outside of Empire’s Service Area. As used in this section, “Out-of-Area Covered Healthcare Services” include emergency care, urgent care, and authorized services obtained outside the geographic area Empire serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These “other services” must be provided or authorized by your Primary Care Physician (“PCP”).

B. BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Empire will remain responsible for fulfilling Empire’s contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue,

where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the applicable Member Cost Share amount, as stated in your Schedule of Benefits.

Emergency Care Services: If you experience a Medical Emergency while traveling outside Empire's Service Area, go to the nearest Emergency, or Urgent Care facility.

Whenever you access covered healthcare services outside Empire's Service Area and, if applicable, Empire's corporate parent's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Empire.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Empire uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if Empire pays the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, Empire may collect such amounts directly from you. You agree that Empire has the right to collect such amounts from you.

SECTION V. WHO IS COVERED

Who is Covered Under this Certificate. You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under this Contract. If You selected one of the following types of coverage, members of Your family may also be covered.

Types of Coverage

In addition to Individual coverage, We offer the following types of coverage:

Individual and Spouse – If You selected Individual and Spouse coverage, then You and Your Spouse are covered.

Parent and Child/Children – If You selected Parent and Child/Children coverage, then You and Your Child or Children, as described below, are covered.

Family – If You selected Family coverage, then You, Your Spouse and Your Children, as described below, are Covered.

Children Covered Under This Certificate

If You selected Parent and Child/Children or Family coverage, “Children” covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child’s adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are not Covered.

Any unmarried dependent Child, regardless of age, who is 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 the Child’s coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child’s attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child’s incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or Covered Subscriber and all other prospective or Covered Members as they pertain to eligibility for coverage under this Certificate at any time.

When Coverage Begins

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber elect coverage before becoming eligible, or within 60 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your group. Groups cannot impose waiting periods that exceed 90 days.
2. If You, the Subscriber do not elect coverage upon becoming eligible or within 60 days of becoming eligible for other than a special enrollment period, You must wait until the group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage within 60 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage. If We do not receive notice within 60 days of the marriage, You must wait until the group's next open enrollment period to add Your Spouse.
4. If You, the Subscriber, have Family or Parent and Child/Children coverage, and have a newborn Child, and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth. If You have Individual or Individual and Spouse coverage, You must notify Us of Your desire to switch to Parent and Child/Children or Family coverage and pay any additional premium within 60 days from the date of birth in order for coverage to start at the moment of birth; otherwise Parent and Child/Children or Family coverage begins on the date on which We receive notice.
5. If You, the Subscriber, have Family or Parent and Child/Children coverage, Your adopted newborn Child will be covered from the moment of birth if You notify Us within 60 days of the birth, You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to section 115-c of the New York Domestic Relations Law or other applicable state law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have Individual or Individual and Spouse coverage, You must also notify Us of Your desire to switch to Parent and Child/Children or Family coverage and pay any additional premium within 60 days from the date of birth in order for coverage to start at the moment of birth. Otherwise Parent and Child/Children or Family coverage begins on the date on which We receive notice and the premium payment. However, We will not provide Hospital benefits for the newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay.

Special Enrollment Periods

You, Your Spouse or Child, can also enroll for coverage within 60 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment.
2. Termination of the other group health plan.
3. Death of the Spouse.
4. Legal separation, divorce or annulment.

5. Reduction of hours of employment.
6. Employer contributions towards the group health plan were terminated; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice and premium payment within 60 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Your Child loses eligibility for Medicaid or a state child health plan.
2. You or Your Spouse or Your Child becomes eligible for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

[Domestic Partner Coverage

This Certificate covers domestic partners of Subscribers as Spouses. If You selected Family coverage, "Children" covered under this Certificate also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
 - a. The affidavit must be notarized and must contain the following:
 - The partners are both eighteen years of age or older and are mentally competent to consent to contract.
 - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York

- The partners have been living together on a continuous basis prior to the date of the application;
 - Neither individual has been registered as a member of another domestic partnership within the last six months; and
- b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
- c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
- A joint bank account
 - A joint credit card or charge card
 - Joint obligation on a loan
 - Status as an authorized signatory on the partner's bank account, credit card or charge card
 - Joint ownership of holdings or investments
 - Joint ownership of residence
 - Joint ownership of real estate other than residence
 - Listing of both partners as tenants on the lease of the shared residence
 - Shared rental payments of residence (need not be shared 50/50)
 - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
 - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
 - Shared household budget for purposes of receiving government benefits
 - Status of one as representative payee for the other's government benefits
 - Joint ownership of major items of personal property (e.g., appliances, furniture)
 - Joint ownership of a motor vehicle
 - Joint responsibility for child care (e.g., school documents, guardianship)
 - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
 - Execution of wills naming each other as executor and/or beneficiary
 - Designation as beneficiary under the other's life insurance policy
 - Designation as beneficiary under the other's retirement benefits account
 - Mutual grant of durable power of attorney
 - Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
 - Affidavit by creditor or other individual able to testify to partners' financial interdependence
 - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.]

SECTION VI. COVERED SERVICES

Preventive Care

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care. We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (“ACIP”). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the telephone number on Your ID card or visit Our website at www.empireblue.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an “A” or “B” rating from USPSTF, and immunizations recommended by ACIP.

A. Well-Baby and Well-Child Care

We Cover well-baby and well-child care which consist of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

B. Adult Annual Physical Examinations

We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

Examples of items or services with an “A” or “B” rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the Covered preventive services is available on Our website at www.empireblue.com, or will be mailed to You upon request.

You are eligible for a physical examination once every calendar year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles 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 and when provided by a Participating Provider.

C. Adult Immunizations

We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. Well-Woman Examinations

We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive services is available on Our website at www.empireblue.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles 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 and when provided by a Participating Provider.

E. Mammograms

We Cover mammograms for the screening of breast cancer as follows:

- one baseline screening mammogram for women age 35 through 39;
- one baseline screening mammogram annually for women age 40 and over.

If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, We Cover mammograms as recommended by her Provider. However, in no event will more than one preventive screening, per Plan Year, be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles 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, which may be less frequent than the above schedule, and when provided by a Participating Provider.

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. However, diagnostic mammograms may be subject to Copayments, Deductibles or Coinsurance.

[F. Family Planning & Reproductive Health Services

We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug benefit in the “Covered Outpatient Prescription Drugs” section of the Certificate, counseling on use of contraceptives, related topics and sterilization procedures for women. Such services are not subject to Copayments, Deductibles 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 and when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.]

[G.] Bone Mineral Density Measurements or Testing

We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the “Prescription Drug Coverage” section of the Certificate. 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. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- 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.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA”) and items or services with an “A” or “B” rating from USPSTF.

This benefit is not subject to Copayments, Deductibles 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, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

[H.] Screening for Prostate Cancer

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other

prostate cancer risk factors. We also Cover 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.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Pre-Hospital Emergency Medical Services and Ambulance Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service. We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed.

“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- 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;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

A New York-licensed ambulance service may not charge or seek reimbursement from You 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 the treatment of an Emergency Condition do not require Preauthorization.

Non-Emergency Ambulance Transportation:

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a Non-Participating Hospital to a Participating Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care Facility.
- From an acute Facility to a sub-acute setting.

See the “Schedule of Benefits” section of this Certificate for any Preauthorization requirements for non-emergency transportation.

Limitations/Terms of Coverage:

Benefits do not include travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician. Non-ambulance transportation such as ambulette, van or taxi cab is not Covered.

Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; **and** Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; **and** one of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (for example, heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Emergency Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Emergency Services for the treatment of an Emergency Condition.

We define an **Emergency Condition** to mean: 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:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;
- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings ; or
- Convulsions.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition.

We define **Emergency Services** to mean: Evaluation of an Emergency Condition and treatment to keep the condition from getting worse including:

- A medical screening examination 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 Condition; and
- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. “To stabilize” is to provide such medical treatment of an Emergency 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 patient from a Facility, or to deliver a newborn child (including the placenta).

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs.

A. Hospital Emergency Department Visits

In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition, as defined above, are Covered in an emergency department.**

Follow-up care or routine care provided in a Hospital emergency department is not Covered.

B. Emergency Hospital Admissions

In the event You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the telephone number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

We Cover inpatient Hospital services at a Non-Participating Hospital for as long as Your medical condition prevents Your transfer to a Participating Hospital. If Your medical condition permits Your transfer to a Participating Hospital We will notify You and arrange the transfer. Any inpatient Hospital services received from a Non-Participating Hospital after we have notified You and arranged for a transfer to a Participating Hospital will not be Covered. See the “Grievance, Utilization Review & External Appeals” section of the Certificate for Your Appeal rights.

C. Payments Relating to Emergency Services Rendered

The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: (1) the amount We have negotiated with Participating Providers for the Emergency Service received (and if more than one amount is negotiated, the median of the amounts); (2) 100% of the Allowed Amount for Services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or (3) the amount that would

be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

You are responsible for any Deductible, Coinsurance or Copayment. You will be held harmless for any Non-Participating Provider charges that exceed Your Coinsurance or Copayment.

Urgent Care

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. **Urgent Care is Covered in or out of Our Service Area.** Urgent Care provided by a Non-Participating Provider in Our Service Area must be Preauthorized.

A. In-Network

You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center. You do not need to contact Us prior to, or after Your visit.

B. Out-of-Network

You may obtain Urgent Care from a Non-Participating Urgent Care Center or Physician outside our Service Area. We do not cover Urgent Care from Non-Participating Urgent Care Centers or Physicians in Our Service Area without a preauthorization.

If Urgent Care results in an Emergency admission please follow the instructions for Emergency Hospital admissions described above.

Outpatient and Professional Services

(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

[Acupuncture: We Cover acupuncture services.]

Advanced Imaging Services: We Cover PET scans, MRI, nuclear medicine, and CAT scans.

Allergy Testing and Treatment: We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

Ambulatory Surgery Center: We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the Center the day the surgery is performed.

Chemotherapy: We Cover Chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the "Prescription Drug Coverage" section of this Certificate.

Chiropractic Services: We Cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") 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 of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

Dialysis: We Cover dialysis treatments of an acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.

- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

Habilitation Services: We Cover Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition, per lifetime.

Home Health Care: We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the Home Health Agency, and (iv) medical supplies, drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 40 visits per Plan year. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Please note: Any rehabilitation services received under this benefit will not reduce the amount of services available under "Rehabilitation and Habilitation Services".

[Interruption of Pregnancy: We Cover therapeutic abortions. We also Cover non-therapeutic abortions in cases of rape, incest or fetal malformation. We Cover elective abortions for one procedure per Member, per Plan Year.]

Infertility Treatment: We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease, or dysfunction. Such Coverage is available as follows:

- Basic Infertility Services. Basic Infertility Services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test,

endometrial biopsy, pelvic ultra sound, hysterosalpingogram, sono-hystogram, testis biopsy, blood tests and medically appropriate treatment of ovulatory dysfunction. Additional tests may be Covered if the tests are determined to be Medically Necessary.

- Comprehensive Infertility Services. If the Basic Services do not result in increased fertility, We Cover Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.
- Exclusions and Limitations
 - a. In vitro, GIFT and ZIFT procedures.
 - b. Cost for an ovum donor or donor sperm.
 - c. Sperm storage costs.
 - d. Cryopreservation and storage of embryos.
 - e. Ovulation predictor kits.
 - f. Reversal of tubal ligations. Reversal of vasectomies.
 - g. All costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers).
 - h. Sex change procedures.
 - i. Cloning.
 - j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.
 - k. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

Infusion Therapy. We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count towards Your home health care visit limit.

Laboratory Procedures, Diagnostic Testing and Radiology Services: We Cover 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.

Maternity and Newborn Care: We Cover services for maternity care provided by a Physician or nurse midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a nurse midwife to be Covered, the nurse midwife must be licensed pursuant to Article 140 of the Education Law, practicing consistent with Section 6951 of the Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the Public Health Law. We will not pay for duplicative routine services provided by both a nurse midwife and a Physician. See the "Inpatient Stay for Maternity Care" section

of the Certificate for coverage of inpatient maternity care.

We Cover the cost of renting one breast pump per pregnancy for the duration of breast feeding.

Office Visits. We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls. We also Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Our telemedicine program. You can check Our Provider directory or contact Us for a listing of the Providers.

Outpatient Hospital Services: We Cover Hospital services and supplies as described in the "Hospital Services" section that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

Preadmission Testing: We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that: the tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed; reservations for a Hospital bed and operating room were made prior to the performance of the tests; surgery takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.

Rehabilitation Services: We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition, per lifetime. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- It is ordered by a Physician; and
- You have been Hospitalized or have undergone surgery for such illness or injury.

Covered speech, physical and occupational therapy services must begin within six months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

Retail Health Clinic Care: Basic health care services provided to Members on a "walk-in" basis. Retail Health Clinics are normally found in major pharmacies or retail stores. Health care

services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Second Opinions:

- Second Cancer Opinion. We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, 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. You may obtain a second opinion from a Non-participating Provider on an In-Network basis when Your attending Physician provides a written Referral to a Non-Participating Specialist.
- Second Surgical Opinion. We Cover a second surgical opinion by a qualified Physician on the need for surgery.
- Required Second Surgical Opinion. We may require a second opinion before We Preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
 - a. The second opinion must be given by a board certified Specialist who personally examines You.
 - b. If the first and second opinions do not agree You may obtain a third opinion.
- Second Opinions in other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will Preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

Surgical Services: We Cover 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. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

Sometimes two or more surgical procedures can be performed during the same operation.

- Through the Same Incision. If Covered multiple surgical procedures are through the same incision, We will pay for the procedure with the highest Allowed Amount.
- Through Different Incisions. If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
 - a. For the procedure with the highest Allowed Amount; and
 - b. 50% of the amount We would otherwise pay for the other procedures.

Oral Surgery: We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

Reconstructive Breast Surgery: We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Implanted breast prostheses following a mastectomy or partial mastectomy are also Covered.

Other Reconstructive and Corrective Surgery: We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when:

- It is performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect; or
- It is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- It is otherwise Medically Necessary.

Transplants: We Cover only those transplants determined to be nonexperimental 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.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. The medical expenses of a non-Member acting as a donor for You are not Covered if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover travel expenses, lodging, meals, or other accommodations for donors or

guests. We do not Cover donor fees in connection with organ transplant surgery. We do not Cover routine harvesting and storage of stem cells from newborn cord blood.

Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Autism Spectrum Disorder: We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, “autism spectrum disorder” means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

- Screening and Diagnosis. We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- Assistive Communication Devices. We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We will not Cover items, such as, but not limited to, laptops, desktop, or tablet computers. We Cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

Repair, replacement fitting and adjustments of such devices are Covered when made necessary by normal wear and tear or significant change in Your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered. Coverage will be provided for the device most appropriate to Your current functional level. We will not provide Coverage for delivery or service charges or for routine maintenance.

- Behavioral Health Treatment. We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. “Applied behavior analysis” 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. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

- Psychiatric and Psychological Care. We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.
- Therapeutic Care. We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.
- Pharmacy Care. We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Certificate.

We will not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under this Certificate for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services Covered under this benefit; and any Deductible, Copayment, or Coinsurance for Prescription Drugs generally will also apply to Prescription Drugs Covered under this benefit. Any Deductible, Copayment, or Coinsurance that applies to Specialist office visits will apply to assistive communication devices Covered under this paragraph.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for

otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

Diabetic Equipment, Supplies and Self-Management Education: We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the Education Law as described below:

Supplies

We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other provider legally authorized to prescribe:

- Acetone Reagent Strips
- Acetone Reagent Tablets
- Alcohol or Peroxide by the pint
- Alcohol Wipes
- All insulin preparations
- Automatic Blood Lance Kit
- Blood Glucose Kit
- Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin Cartridge Delivery
- Insulin infusion devices
- Insulin Pump
- Lancets
- Oral agents such as glucose tablets and gels
- Glucagon for injection to increase blood glucose concentration
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Self-Management Education

Diabetes self-management education is education designed to educate persons with diabetes

as to the proper self-management and treatment of their diabetic condition including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care provider authorized to prescribe under Title 8 of the Education Law, or their staff during an office visit;
- Upon the referral of Your Physician or other health care provider authorized to prescribe under Title 8 of the Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

Limitations

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness.

Durable Medical Equipment and Braces: We Cover the rental or purchase of durable medical equipment and braces.

Durable Medical Equipment

Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- is appropriate for use in the home.

Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment.

Customized or motorized equipment, or equipment designed for Your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) are not Covered as they do not meet the definition of durable medical equipment.

Braces

We Cover braces that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You).

Hearing Aids: We Cover 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.

Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years.

Bone anchored hearing aids are Covered only if You have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one hearing aid per ear during the entire period of time that You are enrolled under this Certificate. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions.

Hospice: Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover 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. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care 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 be certified under a similar certification process required by the state in which the hospice is located. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

Medical Supplies: We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. Please see the "Diabetic Supplies, Education and Self-Management" section of this Certificate for a description of diabetic supply Coverage.

Prosthetics:

External Prosthetic Devices: We Cover 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. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this

section of the Certificate and are only covered under the pediatric vision benefit in the "Pediatric Vision Care" section of this Certificate. We do not Cover orthotics.

For adults, We Cover the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown. Coverage is for standard equipment only. We do not otherwise Cover the cost of repairs or replacement.

We also Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Internal Prosthetic Devices: We Cover 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 You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Inpatient Services

(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Hospital Services: We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and 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 to You;
- 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 provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

Observation Services: We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. The services include use of a bed and periodic monitoring by nursing or other licensed staff.

Inpatient Medical Services: We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

Inpatient Stay for Maternity Care. We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of

whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits that apply to home care benefits.

Inpatient Stay for Mastectomy Care: We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period time determined to be medically appropriate by You and Your attending Physician.

Autologous Blood Banking Services: We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

Rehabilitation Services: We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

1. such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. it is ordered by a Physician; and
3. You have been Hospitalized or have undergone surgery for such illness or injury.

Covered Services must begin within six months of the later to occur:

1. the date of the injury or illness that caused the need for the therapy;
2. the date You are discharged from a Hospital where surgical treatment was rendered; or
3. the date outpatient surgical care is rendered.

Skilled Nursing Facility: We Cover services provided in a Skilled Nursing Facility, including non-custodial care and treatment in a semi-private room, as described in the "Hospital Services" section above. Custodial, convalescent or domiciliary care is not Covered (see the "Exclusions and Limitations" section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us.

End of Life Care: If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 facility or Acute care

Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare acute care service rates.
3. Or if it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare rates.

Limitations/Terms of Coverage:

1. When You are receiving inpatient care in a Hospital or other Facility as described above, We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.
2. We do not Cover radio, telephone and television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Mental Health Care Services

Inpatient Services: We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under this Certificate. However, Coverage for inpatient services for mental health care is limited to Facilities as defined by New York Mental Hygiene Law § 1.03 subdivision 10.

Outpatient Services: We Cover outpatient mental health care services, including but not limited to partial Hospitalization program services 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 NY Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage:

1. We will not Cover benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.
2. We will not Cover mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the Office of Children and Family Services.
3. We will not Cover services solely because they are ordered by a court.

Substance Use Services

Inpatient Services: We Cover 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.

Outpatient Services: We Cover 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 opioid 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 relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

We also Cover 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 Certificate that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Prescription Drug Coverage

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Covered Outpatient Prescription Drugs

We Cover Medically Necessary Outpatient Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription”;
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider’s scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn’s disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the “Infertility Treatment” section of this Certificate.
- Off-Label Cancer drugs, so long as, the Prescription Drug is recognized for the 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.

- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- [Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.]

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at www.empireblue.com. You may also inquire if a specific drug is Covered under this Certificate by contacting us at the telephone number on Your ID card.

Refills

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider and only after $\frac{3}{4}$ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the "Schedule of Benefits" section of this Certificate.

Benefit and Payment Information

1. **Cost-Sharing Expenses:** You are responsible for paying the costs outlined in the "Schedule of Benefits" section of this Certificate when Covered Prescription Drugs are obtained from a retail or mail order or Designated pharmacy.

You have a three tier plan design, which means that Your Out-of-Pocket Expenses will generally be lowest for Prescription Drugs on Tier 1 and highest for Prescription Drugs on Tier 3. Your Out-of-Pocket Expense for Prescription Drugs on Tier 2 will generally be more than for Tier 1 but less than Tier 3.

[An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent Prescription Drug is available on a lower tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance.]

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and Our contracted rates (Our Prescription Drug

Cost) will not be available to You.

2. **Participating Pharmacies:** For Prescription Drugs purchased at a retail or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
 - The applicable Cost-Sharing; or
 - The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the telephone number on Your ID card or visit our website at www.empireblue.com to request approval.

3. **Non-Participating Pharmacies:** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.
4. **Designated Pharmacies:** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have Coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs that are included in this program:

- Eye Conditions
- Anemia, neutropenia, thrombocytopenia
- Contraceptives
- Crohn's Disease
- Cystic Fibrosis
- Cytomegalovirus
- Endocrine disorders/Neurologic disorders such as infantile spasms

- Enzyme Deficiencies/Liposomal Storage Disorders
- Gaucher's Disease
- Growth Hormone
- Hemophilia
- Hepatitis B, Hepatitis C
- Hereditary Angioedema
- HIV/AIDS
- Immune Deficiency
- Immune Modulator
- Infertility
- Iron Overload
- Iron Toxicity
- Multiple Sclerosis
- Oral Oncology
- Osteoarthritis
- Osteoporosis
- Parkinson's Disease
- Pulmonary Arterial Hypertension
- Respiratory Condition
- Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
- Transplant
- RSV Prevention

5. **Mail Order:** We will only cover maintenance drugs through Our participating mail order pharmacy. Other drugs may also be purchased at Our participating mail order pharmacy. You are responsible for paying the lower of:
- The applicable Cost-Sharing; or
 - The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Physician to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order supplier regardless of the number of days supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.empireblue.com or by calling the telephone number on Your ID card. The maintenance drug list is updated periodically.

Call the telephone number on the back of Your ID card to find out if a particular drug is on the maintenance list.

6. **Tier Status:** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.empireblue.com or by calling the telephone number on Your ID card.
7. **When a Brand-Name Drug Becomes Available As a Generic:** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in the “Grievance, Utilization Review and External Appeals” section of the Certificate.
8. **Supply Limits:** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply.

Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two and a half Cost-Share amounts for a 90-day supply. We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a Participating mail order pharmacy.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month’s supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at www.empireblue.com or by calling the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the “Grievance, Utilization Review and External Appeals” section of the Certificate.

9. **Cost-Sharing for Orally-Administered Anti-cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the “Schedule of Benefits” section of this Certificate or the Cost-Sharing amount, if any, that applies to intravenous or injectable

chemotherapy agents Covered under the “Inpatient Services” section of this Certificate.

10. Half Tablet Program. Certain Prescription Drugs may be designated as eligible for Our voluntary half tablet program. This program provides the opportunity to reduce Your Prescription Drug Out-of-Pocket Expenses by up to 50% by using higher strength tablets and splitting them in half. If You are taking an eligible Prescription Drug, and You would like to participate in this program, please call Your Physician to see if the half tablet program is appropriate for Your condition. If Your Physician agrees, he or she must write a new prescription for Your medication to enable Your participation.

You can determine whether a Prescription Drug is eligible for the voluntary half tablet program by accessing Our website at www.empireblue.com or by calling the telephone number on Your ID card.

Medical Management

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug.

For a list of Prescription Drugs that need Preauthorization, please visit our website at www.empireblue.com or call the telephone number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or of any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification. Including a Prescription Drug or related item on the list does not promise coverage under Your Plan. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one type of Prescription Drug before We will Cover another as Medically Necessary. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. The Prescription Drugs that require preauthorization under the Step Therapy Program are also included on the preauthorization drug list.

3. **Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug

substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at www.empireblue.com or call the telephone number on Your ID Card.

Limitations/Terms of Coverage

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.
2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You don't make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.
3. Compounded Prescription Drugs will be Covered only when they contain at least one ingredient that is a Covered legend Prescription Drug, are Medically Necessary, and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over \$250 require Your Provider to obtain Preauthorization. Compounded Prescription Drugs are on tier 3.
4. Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.
5. Injectable drugs (other than self-administered injectable drugs) are not Covered under this section but are Covered under other sections of this Certificate.
6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the "Infusion Therapy" section of this Certificate.
7. We do not Cover drugs that do not by law require a prescription, except as otherwise provided in this Certificate.
8. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.
9. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

10. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
11. Your benefit for diabetic supplies and equipment will be provided under this section of the Certificate if the Cost-Sharing is more favorable to You under this section of the Certificate than the Cost-Sharing under the "Schedule of Benefits" section of the Certificate.
12. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the "Grievance, Utilization Review and External Appeals" section of this Certificate.
13. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.
14. We do not Cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products except as described in the "Covered Outpatient Prescription Drugs" section.

~~[15.—Drugs, procedures and supplies for the treatment of erectile dysfunction are excluded when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to Article 6-C of the Correction Law. Empire must determine your eligibility for coverage of any drug, procedure or supply used for the treatment of erectile dysfunction prior to providing such coverage in accordance with New York State law. We will notify you of our determination regarding your eligibility by written notice. Every notice of denial of coverage shall advise the enrollee how to obtain additional information concerning the denial and the appeal process to challenge the denial. Every denial shall also advise the enrollee that if the enrollee believes that he has been improperly placed on the registry of sex offenders maintained by the New York State Division of Criminal Justice Services, the enrollee should contact that division. The notice shall include the mailing address, telephone number and Web address of the division.]~~

General Conditions

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.
2. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your

coverage. We may, from time-to-time, also enter into agreements that result in Us receiving rebates or other funds (“rebates”) directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member’s utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

Definitions. Terms used in this section are defined as follows. (Other defined terms can be found in the “Definitions” section of this Certificate).

Brand-Name Drug: A Prescription Drug that (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as a “brand name” by the manufacturer, pharmacy, or Your Physician may not be classified as Brand-Name Drug by Us.

Designated Pharmacy: A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

Formulary: The list that identifies those Prescription Drugs for which Coverage may be available under this Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at www.empireblue.com or by calling the telephone number on Your ID card.

Generic Drug: A Prescription Drug that (1) is chemically equivalent to a Brand-Name Drug; or (2) that We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as a “generic” by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by Us.

Non-Participating Pharmacy: A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

Participating Pharmacy: A pharmacy that has:

- entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
- agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- has been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

Prescription Drug: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Prescription Drug Cost: The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Plan includes Coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

Prescription Order or Refill: The directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Usual and Customary Charge: The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the Education Law.

Wellness Benefits

Exercise Facility Reimbursement

We will partially reimburse the Subscriber and the Subscriber's Covered Spouse and eligible Dependents age 18 and over for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual work-out visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (massages, yoga, etc.).

In order to be eligible for reimbursement, You must:

- be an active member of the exercise facility, and
- complete 35 visits in a six-month period.

In order to obtain reimbursement, at the end of the six-month period You must:

- submit a completed reimbursement form. Each time You visit the exercise facility, a facility representative must sign and date the reimbursement form.
- a copy of Your current facility bill which shows the fee paid for Your membership.

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of \$200 for the Subscriber and \$200 for the Subscriber's Spouse and \$200 for each of the Subscriber's eligible Dependents age 18 and over or the actual cost of the membership per six-month period.

Wellness Programs

1. **Purpose.** The purpose of this wellness program is to encourage You to take a more active role in managing Your health and well-being.
2. **Description.** We provide benefits in connection with the following use of or participation in any of the following wellness and health promotion actions and activities:
 - a health risk assessment tool.
 - a designated smoking cessation program.
 - a designated health and fitness incentive program.
 - designated online wellness activities.
3. **Eligibility.** You, the Subscriber, and Your Covered Spouse and Children can participate in the wellness program.
4. **Participation.** The preferred method for accessing the wellness program is through our

website. You need to have access to a computer with Internet access in order to participate in the website program; however, if You do not have access to a computer, please call us at the telephone number on Your ID card and we will provide You with information regarding how to participate on an offline basis.

5. **Rewards.** Rewards for participation in a wellness program include monetary rewards in the form of cash, gift cards or gift certificates, so long as the recipient is encouraged to use the reward for a product or service that promotes good health, such as healthy cook books, over the counter vitamins or exercise equipment.

[[Pediatric] Vision Care

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

[Pediatric] Vision Care: We Cover emergency, preventive and routine vision care[for Children up to age 19].

Vision Examinations: We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination in any twelve (12) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

Prescribed Lenses & Frames: We Cover standard prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.]

[[Pediatric] Dental Care

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

[Pediatric] Dental Care: We Cover the following dental care services[for Children up to age 19]:

Emergency Dental Care: We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

Preventive Dental Care: We Cover preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

Endodontics: We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

Prosthodontics: We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months follow-up care; and
- Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
- For cleft palate stabilization; or

- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

Orthodontics: We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).]

SECTION VII. EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Certificate for the following:

Aviation. We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Convalescent and Custodial Care. We do not Cover services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.

Cosmetic Services. We do not Cover cosmetic services, Prescription Drugs, or surgery except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (for example, certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the "Utilization Review" section of this Certificate.

Coverage Outside of the United States, Canada or Mexico. We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services to treat Your Emergency Condition.

Dental Services. We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as specifically stated in the "Oral Surgery" or "Pediatric Dental Care" section of this Certificate.

Experimental or Investigational Treatment. We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover 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 Certificate for non-investigational treatments. See the "Grievance, Utilization Review and External Appeals" section of this Certificate for a further explanation of Your Appeal rights.

Felony Participation. We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence.

Foot Care. We do not Cover 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 Certificate. For foot care related to diabetes, see the “Diabetic Equipment, Supplies and Self-Management Education” section of this Certificate.

Government Facility. We do not Cover 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 unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

Medically Necessary. In general, We will not Cover any health care service, procedure, treatment, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the procedure, treatment, service, or Prescription Drug for which Coverage has been denied, to the extent that such procedure, treatment, service, or Prescription Drug is otherwise Covered under the terms of this Certificate.

Medicare or Other Governmental Program. We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

Military Service. We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance. We do not Cover 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 if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services Separately Billed by Hospital Employees. We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services Provided by a Family Member. We do not Cover 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 You or Your spouse.

Services With No Charge. We do not Cover services for which no charge is normally made.

Services not Listed. We do not Cover services that are not listed in this Certificate as being Covered.

Vision Services. We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the “Pediatric Vision Care” section of this Certificate.

Workers’ Compensation. We do not Cover services if benefits for such services are provided under any state or federal Workers’ Compensation, employers’ liability or occupational disease

law.

War. We will not Cover an illness, treatment or medical condition due to war, declared or undeclared.

SECTION VIII. CLAIM DETERMINATIONS

Claims. A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider you will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

Notice of Claim. Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the telephone number on your ID card or visiting Our website at www.empireblue.com. Completed claim forms should be sent to the address in the "Important Telephone Numbers and Addresses" section of this Certificate.

Timeframe for Filing Claims. Claims for services must be submitted to Us for payment within 15 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 15 month period, You must submit it as soon as reasonably possible.

Claims for Prohibited Referrals. We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by N.Y. Public Health Law § 238-a(1).

Claim Determinations. Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to the "Grievance, Utilization Review and External Appeals" section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see the "Grievance, Utilization Review and External Appeals" section of this Certificate.

A pre-service claim is a request that a service or treatment be approved before it has been received. A post-service claim is a request for a service or treatment that You have already received.

Pre-service Claim Determinations.

If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and

provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Pre-service Reviews. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notice will follow within three calendar days of the decision.

Post-service Claim Determinations.

If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

SECTION IX. GRIEVANCE, UTILIZATION REVIEW AND EXTERNAL APPEALS

Grievance Procedures

Grievances. Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

Filing a Grievance. You can contact Us by phone at the telephone number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

Grievance Determination. Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for service.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

Grievance Appeals. If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances: The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances: 15 calendar days of receipt of Your Appeal
(A request for a service or treatment that has not yet been provided.)

Post-Service Grievances: 30 calendar days of receipt of Your Appeal
(A claim for a service or a treatment that has already been provided.)

All Other Grievances: 30 business days of receipt of all necessary information to make a determination
(That are not in relation to a claim or request for service.)

If You remain dissatisfied with Our Appeal determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Health at

1-800-206-8125 or write them at:

New York State Department of Health
Bureau of Certification and Surveillance
Corning Tower
Empire State Plaza
Albany, NY 12237
www.health.ny.gov

Call the New York State Department of Financial Services at

1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza

Albany, NY 12257
www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates

105 East 22nd Street

New York, NY. 10010

Or call toll free: 1-888-614-5400

Or e-mail cha@cssny.org

Utilization Review

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the telephone number on Your ID card.

All determinations that services are not Medically Necessary will be made by licensed Physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, You can contact Us or visit our website at www.empireblue.com.

Preauthorization Reviews

If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of receipt of the request.

If We need additional information, We will request it within 3 business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within one calendar day of the decision. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period.

After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We

will not deny coverage for home care services while Our decision on the request is pending.

Concurrent Reviews

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of all necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day time period.

Urgent Concurrent Reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent Preauthorization Review timeframes apply.

Retrospective Reviews

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a Utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

Reconsideration

If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

Utilization Review Internal Appeals

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a Utilization Review Appeal if the service you request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an Out-of-Network health service, You, or Your designee, must submit:

- A statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested Out-of-Network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
- Two documents from the available medical and scientific evidence that the Out-of-Network service:
 - a. Is likely to be more clinically beneficial to You than the alternate In-Network service; and
 - b. that the adverse risk of the Out-of-Network service would likely not be substantially increased over the In-Network health service.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and telephone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

Standard Appeal

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be

provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeals. Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited Appeals are not available for retrospective reviews. For expedited Appeals, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of 72 hours from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

External Appeals

YOUR RIGHT TO AN EXTERNAL APPEAL

In some cases, You have a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
 - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in I above.

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL

If We have denied coverage on the basis that the service is an experimental or investigational treatment, You must satisfy the two requirements for an external appeal in I above and Your attending Physician must certify that: (1) Your condition or disease is one for which standard health services are ineffective or medically inappropriate; **or** (2) one for which there does not exist a more beneficial standard service or procedure covered by Us; **or** (3) one for which

there exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS OUT-OF-NETWORK

If We have denied coverage of an Out-of-Network treatment because it is not materially different than the health service available In-Network, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in I above, and You have requested preauthorization for the Out-of-Network treatment.

In addition, Your attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended In-Network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate In-Network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate In-Network health service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

You do not have a right to an external appeal for a denial of a Referral to an Out-of-Network provider on the basis that a health care provider is available In-Network to provide the particular health service requested by You.

THE EXTERNAL APPEAL PROCESS

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an Out-of-Network treatment We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the costs of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this

Certificate for non-experimental or non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

YOUR RESPONSIBILITIES

It is Your RESPONSIBILITY to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION X. COORDINATION OF BENEFITS

This section applies when you also have group health coverage with another plan. When You receive a Covered service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This prevents duplicate payments and overpayments.

Definitions

“Allowable expense” is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

“Plan” is other group health coverage with which We will coordinate benefits. The term “plan” includes:

1. Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
2. Medical benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
3. Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

“Primary plan” is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: (1) the plan has no order of benefits rules or its rules differ from those required by regulation; or (2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

“Secondary plan” is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Rules to Determine Order of Payment

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will

be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.
2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
 - a. The plan of the parent who has custody will be primary;
 - b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
 - c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our

obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Necessary Information

We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

Our Right to Recover Overpayment

If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

Coordination with “Always Excess,” “Always Secondary,” or “Non-Complying” Plans

We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.
2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer;
3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION XI. TERMINATION OF COVERAGE

Coverage under this Certificate will automatically be terminated on the first of the following to apply. In all cases of termination, unless otherwise noted below, We will provide at least 30 days prior written notice to the Group.

1. The Group, and/or Subscriber, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless You have coverage for Dependents. If You have coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the end of the month in which the Child turns 26 years of age. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.
6. The end of the month during which the Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
7. If a Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. However, if a Subscriber makes an intentional misrepresentation of material fact in writing on his/her enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate.
8. The date that the Group Contract is terminated. If We terminate and/or decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days prior written notice.
9. If We elect to terminate or cease offering all hospital, surgical and medical expense coverage in the small group market, in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.
10. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

11. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage.

12. The date there is no longer any enrollee who lives, resides, or works in Our Service Area.

No termination of coverage shall prejudice the right to a claim for benefits which arose prior to such termination.

See the "Continuation of Coverage" section of this Certificate for Your right to continuation of this coverage and the "Conversion Right to New Contract After Termination" section of this Certificate for Your right to conversion to an individual Contract.

SECTION XII. WHAT HAPPENS IF YOU LOSE COVERAGE

Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Contract terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, total disability means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

When You May Continue Benefits

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your 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.

Termination of Extension of Benefits

Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment);
- With respect to the 12 month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

Limits on Extended Benefits

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends;
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g. a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your Covered Children.
2. If You are a Covered Spouse, You may continue coverage if Your coverage ends due to:
 - a. Voluntary or involuntary termination of the Covered employee's employment;
 - b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
 - c. Divorce or legal separation of the Covered employee;
 - d. Death of the Covered employee; or
 - e. The Covered employee becoming entitled to Medicare.
3. If You are a Covered Child, You may continue coverage if Your coverage ends due to:
 - a. Voluntary or involuntary termination of the Covered employee's employment;
 - b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
 - c. Loss of Covered Child status under the plan rules;
 - d. Death of the Covered employee; or
 - e. The Covered employee becoming entitled to Medicare.

If You want to continue coverage You must request continuation from Your employer in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group Contractholder.

The Group Contractholder can charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 36 months after Your coverage would have terminated because of termination of employment;
2. If You are a Covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the employee, divorce or legal separation, the employee's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become Covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See the "Conversion Right to New Contract After Termination" section of the Certificate.

Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
2. You serve no more than four years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group Contractholder the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your Covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which

active duty terminated.

2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one year.

Age 29 Dependent Coverage Extensions Young Adult Option

Your Child may be eligible to purchase his or her own individual coverage under Your Group's Contract through the age of 29 if he or she 1) is under the age of 30; 2) is not married; 3) is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; 4) lives, works or resides in New York State or Our Service Area; and 5) is not covered by Medicare. The Child may purchase coverage even if he or she is not financially Dependent on his or her parent(s) and does not need to live with his or her parent(s).

Your Child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the Group Contractholder or Group Contractholder's designee receives notice and We receive Premium payment;
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when the Group Contractholder or Group Contractholder's designee receives notice of election and We receive Premium payment.

You or Your Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. Your Child's children are not eligible for coverage under this option.

Conversion Right to New Contract After Termination

You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.

- 1. Termination of the Group Contract.** If the Group Contract between Us and the Group Contractholder is terminated as set forth in the “Termination of Coverage” section of this Certificate, and the Group Contractholder has not replaced the coverage for the Group with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as direct payment members.
- 2. If You Are No Longer Covered in a Group.** If Your coverage terminates under the “Termination of Coverage” section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.
- 3. On the Death of the Subscriber.** If coverage terminates under the “Termination of Coverage” section of this Certificate because of the death of the Subscriber, the Subscriber’s Dependents are entitled to purchase a new Contract as direct payment members.
- 4. Termination of Your Marriage.** If a Spouse’s coverage terminates under the “Termination of Coverage” section of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.
- 5. Termination of Coverage of a Child.** If a Child’s coverage terminates under the “Termination of Coverage” section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.
- 6. Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the “Termination of Coverage” section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.
- 7. Termination of Your Young Adult Coverage.** If a Child’s young adult coverage terminates under the “Termination of Coverage” section of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.

When to Apply for the New Contract. If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 45 days after termination of coverage under this Certificate. You must also pay the first Premium of the new Contract at the time You apply for coverage.

The New Contract. We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. You may choose among any of the four Contracts offered by Us. However, the coverage may not be the same as Your current coverage. However, if We determine that You do not reside in New York State, We may issue You or Your family members coverage on a form that we use for conversion in that state.

When Conversion is Not Available. We will not issue You an individual direct payment Contract if the issuance of the new Contract will result in overinsurance or duplication of benefits according to the standards We have on file with the Superintendent of the New York State Department of Financial Services.

SECTION XIII. GENERAL PROVISIONS

1. **Agreements between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.
2. **Assignment.** You cannot assign any benefits or monies due under this Certificate to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or your right to collect money from us for those services.
3. **Changes in This Certificate.** We may unilaterally change this Certificate upon renewal, if We give the Group Contractholder 30 days' prior written notice.
4. **Choice of Law.** This Certificate shall be governed by the laws of the State of New York.
5. **Clerical Error.** Clerical error, whether by the Group Contractholder or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.
6. **Continuation of Benefit Limitations.** Some of the benefits under this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.
7. **Enrollment ERISA.** The Group Contractholder will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all group members covered under this Certificate, and any other information required to confirm their eligibility for coverage. The Group Contractholder will provide Us with this information upon request.

The Group Contractholder may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The "plan administrator" is the Group Contractholder, or a third party appointed by the Group Contractholder. We are not the ERISA plan administrator.

8. **Entire Agreement.** This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

9. **Furnishing Information and Audit.** The Group Contractholder and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group Contractholder will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to group enrollment at the Group Contractholder's New York office.
10. **Identification Cards.** Identification cards are issued by Us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.
11. **Incontestability.** No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.
12. **Independent Contractors.** Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's facility.
13. **Material Accessibility.** We will give the Group Contractholder, and the Group Contractholder will give You, identification cards, Certificates, riders, and other necessary materials.
14. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.
- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
 - The information that We provide the State regarding Our consumer complaints.
 - A copy of Our procedures for maintaining confidentiality of Member information.
 - A copy of Our drug formulary. You may also inquire if a specific drug is Covered under

this Certificate.

- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with Participating Hospitals.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.

15. **Notice.** Any notice that We give to You under this Certificate will be mailed to Your address as it appears on our records or to the address of the Group Contractholder. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: [Empire Member Services, P.O. Box 1407, Church Street Station, New York, NY 10008].

16. **Premium Refund.** We will give any refund of Premiums, if due, to the Group Contractholder.

17. **Recovery of Overpayments.** On occasion a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

18. **Renewal Date.** The renewal date for the Certificate is the anniversary of the effective date of the Group Contract in each Year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us or the Group Contractholder as permitted by the Certificate, or by You upon 30 days' prior written notice to the Group Contractholder.

19. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will make or will not make payments under this Certificate. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether surgery was Medically Necessary to treat Your illness or injury; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules

pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

20. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.
21. **Service Marks.** Empire HealthChoice HMO, Inc. (Empire) is an independent corporation organized under the New York Insurance Law. Empire also operates under licenses with the Blue Cross and Blue Shield Association, which licenses Empire to use the Blue Cross and/or Blue Shield service marks in a portion of New York State. Empire does not act as an agent of the Blue Cross and Blue Shield Association. Empire is solely responsible for the obligations created under this agreement.
22. **Severability.** The unenforceability or invalidity of any provision of the Certificate shall not affect the validity and enforceability of the remainder of the Certificate.
23. **Significant Change in Circumstances.** If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.
24. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Certificate. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract

between You and us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

25. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 2 years from the date the claim was required to be filed.
26. **Translation Services.** Translation services are available under this Certificate for non-English speaking Members. Please contact us at the telephone number on Your ID card to access these services.
27. **Venue for Legal Action.** If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to these courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order You to defend any action We bring against You.
28. **Waiver.** The waiver by any party of any breach of any provision of the Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.
29. **Who May Change This Certificate.** The Certificate may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.
30. **Who Receives Payment under This Certificate.** Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.
31. **Workers' Compensation Not Affected.** The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation

insurance or law.

32. Your Medical Records and Reports. In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.