Filing at a Glance

Company:	Excellus Health Plan, Inc.
Product Name:	ExchangeBlue EPO/Exchange Univera EPO
State:	New York
TOI:	H15I Individual Health - Hospital/Surgical/Medical Expense
Sub-TOI:	H15I.001 Health - Hospital/Surgical/Medical Expense
Filing Type:	Exchange Forms & Rates
Date Submitted:	04/24/2013
SERFF Tr Num:	EXHP-128987637
SERFF Status:	Pending State Action
State Tr Num:	2013040122
State Status:	CR Awaiting Company Response
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *New York* **Filing Company:** *Excellus Health Plan, Inc.*
TOI/Sub-TOI: *H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name: *ExchangeBlue EPO/Exchange Univera EPO*
Project Name/Number: *Individual On/Off Exchange/*

General Information

Project Name: Individual On/Off Exchange
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: [redacted]

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 06/03/2013
State Status Changed: 05/17/2013
Created By: [redacted]
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions:

With the exception of a single Schedule of Benefits and rider, all forms and rates included in this filing are for health plans intended to be sold on the New York Health Benefit Exchange.

Filing Description:

This filing includes four Exclusive Provider Organization contracts, 28 Schedules of Benefits, and two riders, all of which are specifically identified by form number on the Form Schedule. The products will be marketed both on and off the New York Health Benefit Exchange, with the exception of the Out-of-Network Benefits Rider (EXER-2) and associated Schedule of Benefits (EXES-32), which will be sold off the Exchange only. In the Plan's "Blue" counties the EPO plans will be sold under the product name ExchangeBlue EPO and in the Plan's Univera counties under the product name Exchange Univera EPO. In addition, the Plan will be offering a two-tiered network product in Delaware, Herkimer, and Otsego ("Blue") counties under the product name Bassett.

The Plan requests that the Actuarial Memorandum be exempt from disclosure under Public Officers Law Section 87 (2) (d), since it constitutes trade secrets that, if disclosed, would cause substantial injury to the Plan's competitive position.

Company and Contact

Filing Contact Information

[redacted], Coordinator, Contract Development
165 Court Street
Rochester, NY 14647

[redacted]
[redacted]
[redacted]

Filing Company Information

Excellus Health Plan, Inc.
165 Court Street
Rochester, NY 14647
(585) 454-1700 ext. [Phone]

CoCode: 55107
Group Code: 99
Group Name:
FEIN Number: 15-0329043

State of Domicile: New York
Company Type: Article 43 Health Insurer
State ID Number:

Filing Fees

State:	*New York*	**Filing Company:**	*Excellus Health Plan, Inc.*
TOI/Sub-TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense*		
Product Name:	*ExchangeBlue EPO/Exchange Univera EPO*		
Project Name/Number:	*Individual On/Off Exchange/*		

Fee Required? No

Retaliatory? No

Fee Explanation:

State Specific

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.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Article 43
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): No
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Form and Rate
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: No
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): Not applicable. This is not a rate adjustment filing pursuant to Section 4308(c).

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):
Excellus Health Plan, Inc.	New Product	%	%				%	%

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

State: *New York* **Filing Company:** *Excellus Health Plan, Inc.*
TOI/Sub-TOI: *H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name: *ExchangeBlue EPO/Exchange Univera EPO*
Project Name/Number: *Individual On/Off Exchange/*

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Manual Individual 2014	EXEC-1, EXEC-2, EXEC-3, EXEC-4, EXER-1, EXER-2	New		Rate Manual Individual 2014 (05-22-13).pdf,

Excellus Health Plans, Inc
dba

Excellus BCBS, Univera Healthcare

INDIVIDUAL Market
On-Exchange and Off-Exchange

Documentation in Support of
New York State
Section 4308(b) Rate Submission

Rate Manual
Effective January 1, 2014

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- **Buffalo** pages 14-15

Outline of Benefits pages 17-45

Commission Schedule pages 52-61

Underwriting Guidelines
- **Excellus BCBS** pages 52-61
- **Univera Healthcare** pages 62-71

Expected Loss Ratio page 73

Rate Manual Pages

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Premium Rates -Rochester Region

Option	HIOS Plan ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-1[no Pediatric Dental]						
EXEC-1[no Pediatric Dental],EXER-1						
EXEC-1[with Pediatric Dental]						
EXEC-1[with Pediatric Dental],EXER-1						
EXEC-2[no Pediatric Dental]						
EXEC-2[with Pediatric Dental]						

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014

Community Rated

2014 Individual Premium Rates -Rochester Region

Option	HIOS Plan ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-3[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-3[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090004	595.22	1,190.44	1,011.88	1,696.37	NA
EXEC-1, EXER-2[no Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090002	606.53	1,213.06	1,031.11	1,728.60	NA
EXEC-1, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090003	602.62	1,205.24	1,024.46	1,717.46	NA
EXEC-1, EXER-2[with Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090001	614.07	1,228.14	1,043.92	1,750.09	NA
EXEC-2, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	245.23
EXEC-2, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	248.28

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014

Community Rated

2014 Individual Premium Rates - Syracuse Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-1[no Pediatric Dental]						
EXEC-1[no Pediatric Dental],EXER-1						
EXEC-1[with Pediatric Dental]						
EXEC-1[with Pediatric Dental],EXER-1						
EXEC-2[no Pediatric Dental]						
EXEC-2[with Pediatric Dental]						

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014

Community Rated

2014 Individual Premium Rates - Syracuse Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-3[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-3[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090004	681.38	1,362.75	1,158.35	1,941.92	NA
EXEC-1, EXER-2[no Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090002	694.33	1,388.64	1,180.36	1,978.82	NA
EXEC-1, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090003	688.78	1,377.55	1,170.93	1,963.01	NA
EXEC-1, EXER-2[with Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090001	701.87	1,403.72	1,193.18	2,000.31	NA
EXEC-2, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	280.73
EXEC-2, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	283.78

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Premium Rates - Utica/Watertown Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-1[no Pediatric Dental]						
EXEC-1[no Pediatric Dental],EXER-1						
EXEC-1[with Pediatric Dental]						
EXEC-1[with Pediatric Dental],EXER-1						
EXEC-2[no Pediatric Dental]						
EXEC-2[with Pediatric Dental]						

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014

Community Rated

2014 Individual Premium Rates - Utica/Watertown Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-3[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-3[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[no Pediatric Dental],EXER-1						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[with Pediatric Dental],EXER-1						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090004	725.28	1,450.55	1,232.97	2,067.04	NA
EXEC-1, EXER-2[no Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090002	739.06	1,478.11	1,256.40	2,106.31	NA
EXEC-1, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090003	732.68	1,465.35	1,245.55	2,088.13	NA
EXEC-1, EXER-2[with Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090001	746.60	1,493.19	1,269.22	2,127.80	NA
EXEC-2, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	298.81
EXEC-2, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	301.86

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Premium Rates -Albany Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-1[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1[no Pediatric Dental],EXER-1						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1[with Pediatric Dental],EXER-1						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-2[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-2[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014

Community Rated

2014 Individual Premium Rates -Albany Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-3[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-3[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[no Pediatric Dental],EXER-1						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[with Pediatric Dental],EXER-1						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090004	725.28	1,450.55	1,232.97	2,067.04	NA
EXEC-1, EXER-2[no Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090002	739.06	1,478.11	1,256.40	2,106.31	NA
EXEC-1, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090003	732.68	1,465.35	1,245.55	2,088.13	NA
EXEC-1, EXER-2[with Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090001	746.60	1,493.19	1,269.22	2,127.80	NA
EXEC-2, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	298.81
EXEC-2, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	301.86

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014

Community Rated

2014 Individual Premium Rates - Mid-Hudson Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-1[no Pediatric Dental]						
EXEC-1[no Pediatric Dental],EXER-1						
EXEC-1[with Pediatric Dental]						
EXEC-1[with Pediatric Dental],EXER-1						
EXEC-2[no Pediatric Dental]						
EXEC-2[with Pediatric Dental]						

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014

Community Rated

2014 Individual Premium Rates - Mid-Hudson Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-3[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-3[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[no Pediatric Dental],EXER-1						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-4[with Pediatric Dental],EXER-1						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090004	725.28	1,450.55	1,232.97	2,067.04	NA
EXEC-1, EXER-2[no Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090002	739.06	1,478.11	1,256.40	2,106.31	NA
EXEC-1, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090003	732.68	1,465.35	1,245.55	2,088.13	NA
EXEC-1, EXER-2[with Pediatric Dental],EXER-1						
Excellus BCBS Platinum Standard IND PPO	78124NY1090001	746.60	1,493.19	1,269.22	2,127.80	NA
EXEC-2, EXER-2[no Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	298.81
EXEC-2, EXER-2[with Pediatric Dental]						
Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	301.86

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014

Community Rated

2014 Individual Premium Rates - Buffalo Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-1[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1[no Pediatric Dental],EXER-1						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Premium Rates - Buffalo Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
EXEC-3[no Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-3[with Pediatric Dental]						
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EXEC-1, EXER-2[no Pediatric Dental]						
Univera Platinum Standard IND PPO	78124NY1100004	704.70	1,409.41	1,198.00	2,008.40	NA
EXEC-1, EXER-2[no Pediatric Dental],EXER-1						
Univera Platinum Standard IND PPO	78124NY1100002	718.09	1,436.19	1,220.76	2,046.56	NA
EXEC-1, EXER-2[with Pediatric Dental]						
Univera Platinum Standard IND PPO	78124NY1100003	711.10	1,422.21	1,208.88	2,026.64	NA
EXEC-1, EXER-2[with Pediatric Dental],EXER-1						
Univera Platinum Standard IND PPO	78124NY1100001	724.61	1,449.23	1,231.85	2,065.15	NA
EXEC-2, EXER-2[no Pediatric Dental]						
Univera Platinum Standard IND PPO	78124NY1100006	NA	NA	NA	NA	290.34
EXEC-2, EXER-2[with Pediatric Dental]						
Univera Platinum Standard IND PPO	78124NY1100005	NA	NA	NA	NA	292.98

Outline of Benefits

Effective Date: January 1, 2014
Community Rated

2014 Individual On & Off Exchange - All Regions

Option	HIOS ID	Plan Design	Single Ded.	Coins. IN	PCP Copay	SPC Copay	Single OOP Max	Rx	Dependent Coverage	On/Off Exchange
EXEC-1[no Pediatric Dental] Exclusive Provider Organization Contract										
EXEC-1[no Pediatric Dental],EXER-1 Exclusive Provider Organization Contract										
EXEC-1[with Pediatric Dental] Exclusive Provider Organization Contract										
EXEC-1[with Pediatric Dental],EXER-1 Exclusive Provider Organization Contract										
EXEC-2[no Pediatric Dental] Exclusive Provider Organization Contract (Child)										
EXEC-2[with Pediatric Dental] Exclusive Provider Organization Contract (Child)										
EXEC-3[no Pediatric Dental] Exclusive Provider Organization Contract (Catastrophic Plan)										
EXEC-3[with Pediatric Dental] Exclusive Provider Organization Contract (Catastrophic Plan)										
EXEC-4[no Pediatric Dental] Exclusive Provider Organization Contract (2-Tier Network)										
EXEC-4[no Pediatric Dental],EXER-1 Exclusive Provider Organization Contract (2-Tier Network)										
EXEC-4[with Pediatric Dental] Exclusive Provider Organization Contract (2-Tier Network)										
EXEC-4[with Pediatric Dental],EXER-1 Exclusive Provider Organization Contract (2-Tier Network)										
EXEC-1,EXER-2[no Pediatric Dental] Preferred Provider Organization Contract										

Excellus Health Plan, Inc.
Excellus BlueCross BlueShield

Effective Date: January 1, 2014
Community Rated

2014 Individual On & Off Exchange - All Regions

Option	HIOS ID	Plan Design	Single Ded.	Coins. IN	PCP Copay	SPC Copay	Single OOP Max	Rx	Dependent Coverage	On/Off Exchange
EXEC-1,EXER-2[no Pediatric Dental],EXER-1										
Preferred Provider Organization Contract										
Excellus BCBS Platinum Standard IND PPO	78124NY1090002	Copay	0	0%	15	35	2000	$10/$30/$60	Through age 29	Off
EXEC-1,EXER-2[with Pediatric Dental]										
Preferred Provider Organization Contract										
Excellus BCBS Platinum Standard IND PPO	78124NY1090003	Copay	0	0%	15	35	2000	$10/$30/$60	To age 26	Off
EXEC-1,EXER-2[with Pediatric Dental],EXER-1										
Preferred Provider Organization Contract										
Excellus BCBS Platinum Standard IND PPO	78124NY1090001	Copay	0	0%	15	35	2000	$10/$30/$60	Through age 29	Off
EXEC-2,EXER-2[no Pediatric Dental]										
Preferred Provider Organization Contract										
Excellus BCBS Platinum Standard IND PPO	78124NY1090006	Copay	0	0%	15	35	2000	$10/$30/$60	N/A	Off
EXEC-2,EXER-2[with Pediatric Dental]										
Preferred Provider Organization Contract										
Excellus BCBS Platinum Standard IND PPO	78124NY1090005	Copay	0	0%	15	35	2000	$10/$30/$60	N/A	Off

Excellus Health Plan, Inc.
Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual On & Off Exchange - Buffalo Region

Option	HIOS ID	Plan Design	Single Ded.	Coins. IN	PCP Copay	SPC Copay	Single OOP Max	Rx	Dependent Coverage	On/Off Exchange
EXEC-1[no Pediatric Dental]										
Exclusive Provider Organization Contract										
EXEC-1[no Pediatric Dental],EXER-1										
Exclusive Provider Organization Contract										
EXEC-1[with Pediatric Dental]										
Exclusive Provider Organization Contract										
EXEC-1[with Pediatric Dental],EXER-1										
Exclusive Provider Organization Contract										
EXEC-2[no Pediatric Dental]										
Exclusive Provider Organization Contract (Child)										
EXEC-2[with Pediatric Dental]										
Exclusive Provider Organization Contract (Child)										
EXEC-3[no Pediatric Dental]										
EXEC-3[with Pediatric Dental]										
EXEC-1,EXER-2[no Pediatric Dental]										
Preferred Provider Organization Contract										
Univera Platinum Standard IND PPO	78124NY1100004	Copay	0	0%	15	35	2000	$10/$30/$60	To age 26	Off
EXEC-1,EXER-2[no Pediatric Dental],EXER-1										
Preferred Provider Organization Contract										
Univera Platinum Standard IND PPO	78124NY1100002	Copay	0	0%	15	35	2000	$10/$30/$60	Through age 29	Off
EXEC-1,EXER-2[with Pediatric Dental]										
Preferred Provider Organization Contract										
Univera Platinum Standard IND PPO	78124NY1100003	Copay	0	0%	15	35	2000	$10/$30/$60	To age 26	Off
EXEC-1,EXER-2[with Pediatric Dental],EXER-1										
Preferred Provider Organization Contract										
Univera Platinum Standard IND PPO	78124NY1100001	Copay	0	0%	15	35	2000	$10/$30/$60	Through age 29	Off
EXEC-2,EXER-2[no Pediatric Dental]										
Preferred Provider Organization Contract										
Univera Platinum Standard IND PPO	78124NY1100006	Copay	0	0%	15	35	2000	$10/$30/$60	N/A	Off
EXEC-2,EXER-2[with Pediatric Dental]										
Preferred Provider Organization Contract										
Univera Platinum Standard IND PPO	78124NY1100005	Copay	0	0%	15	35	2000	$10/$30/$60	N/A	Off

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EXEC-3 (Exclusive Provider Organization, Catastrophic Plan);
EXER-2 (Out of Network Rider)
Platinum, Gold, Silver Standard
NYS Benchmark Plan
Individual

		On Exchange	Off Exchange Rider
Benefit Type	**In-Network**	**Out-of-Network**	**Out-of-Network**
PROVIDER NETWORK & SERVICE AREA			
Provider Network Counties - BCBS	BCBS 31 counties only		
Provider Network Counties - Univera	39 Counties: BCBS 31 plus Univera 8		
BCBS Service Area	**Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson**		
Univera Service Area	**Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming.**		
WHO IS COVERED			
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family		
Dependent Coverage **Federal Mandate**	26 to end of month of birthday		
Dependents through age 29 **State Mandate**	Dependent Make Available		
Domestic Partner Coverage	Covered - standard		
COST SHARING EXPENSES			
Contract Year	Calendar Year		
Deductible **· Single/ Family**	Single: Platinum: $[0] [redacted] Family = 2X single	[redacted]	Single: $500 Family: $1,000
4th Quarter Deductible Carry-Over Y/N	No	[redacted]	No
Copayment	Platinum: $[15] PCP/ $[35] SPC [redacted]	[redacted]	Not Covered Platinum Rider: None
Coinsurance	Platinum, Gold, Silver, Silver CSR: None	[redacted]	20%
Annual Out-of-Pocket Maximum	Single: Platinum: $[2,000] [redacted]	[redacted]	Single: $2,000 Family: $4,000
Annual Benefit Maximum **Federal Mandate**	None	[redacted]	None
Lifetime Benefit Maximum **Federal Mandate**	None	[redacted]	None
HOSPITAL INPATIENT SERVICES		[redacted]	
Inpatient Hospital Services **NYS & Federal Essential Health Benefit**	Platinum: $[500] copay per admission [redacted]	[redacted]	Deduct/Coins
Mental Health Care **NYS & Federal Essential Health Benefit**	Inpatient Hospital cost share applies.	[redacted]	Inpatient Hospital cost share applies.
Residential Treatment	Not Covered	[redacted]	Not Covered
Substance Use Detoxification **NYS & Federal Essential Health Benefit**	Inpatient Hospital cost share applies.	[redacted]	Inpatient Hospital cost share applies.
Substance Use Rehabilitation **NYS & Federal Essential Health Benefit**	Inpatient Hospital cost share applies. Unlimited days	[redacted]	Inpatient Hospital cost share applies.
Skilled Nursing Facility **NYS & Federal Essential Health Benefit**	Inpatient Hospital cost share applies.	[redacted]	Inpatient Hospital cost share applies.
Physical Rehabilitation **includes habilitative services** **NYS & Federal Essential Health Benefit**	Inpatient Hospital cost share applies.	[redacted]	Inpatient Hospital cost share applies.
Maternity Care **NYS & Federal Essential Health Benefit**	Inpatient Hospital cost share applies.	[redacted]	Inpatient Hospital cost share applies.
Maternity Care – Routine Newborn Nursery **NYS & Federal Essential Health Benefit**	Covered in Full	[redacted]	Deduct/Coins
Implanted Devices **NYS & Federal Essential Health Benefit**	Covered in Full	[redacted]	Deduct/Coins
End of Life Care **State Mandate** **NYS Essential Health Benefit**	Inpatient Hospital cost share applies.	[redacted]	Inpatient Hospital cost share applies.

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		On Exchange	Off Exchange Rider
Benefit Type	**In-Network**	**Out-of-Network**	**Out-of-Network**
Observation Stay **NYS & Federal Essential Health Benefit**	Platinum: $[100] copay [redacted]	[redacted]	Deduct/Coins
HOME CARE **NYS & Federal Essential Health Benefit**	up to $50 Deduct when applicable, PCP Copay	[redacted]	Deduct/Coins
HOSPICE CARE **NYS & Federal Essential Health Benefit**	Inpatient: Inpatient Hospital cost share applies. Hospice facility or Home: PCP copay per visit	[redacted]	Deduct/Coins
HOSPITAL OUTPATIENT SERVICES		[redacted]	
Surgical Care including Surgicenters & Freestanding Facilities **NYS & Federal Essential Health Benefit**	Platinum: $[100] copay [redacted]	[redacted]	Deduct/Coins
Pre-admission/Pre-Operative Testing **NYS & Federal Essential Health Benefit**	Covered in full	[redacted]	Deduct/Coins
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**	Specialist Copay	[redacted]	Deduct/Coins
Advanced Imaging Services **NYS & Federal Essential Health Benefit**	Specialist Copay	[redacted]	Deduct/Coins
Diagnostic & Routine Laboratory and Pathology **NYS & Federal Essential Health Benefit**	Specialist Copay	[redacted]	Deduct/Coins
Radiation Therapy **NYS & Federal Essential Health Benefit**	PCP Copay per visit	[redacted]	Deduct/Coins
Chemotherapy **NYS & Federal Essential Health Benefit**	PCP Copay per visit	[redacted]	Deduct/Coins
Infusion Therapy **NYS Essential Health Benefit**	PCP Copay per visit	[redacted]	Deduct/Coins
Dialysis (all forms) **NYS & Federal Essential Health Benefit**	PCP Copay per visit	[redacted] a only:	Deduct/Coins
Mental Health Care **NYS & Federal Essential Health Benefit**	PCP Copay per visit	[redacted]	Deduct/Coins
Autism Applied Behavior Analysis State Mandate **NYS Essential Health Benefit**	PCP Copay per visit	[redacted]	Deduct/Coins
Substance Use Services **NYS & Federal Essential Health Benefit**	PCP Copay per visit	[redacted]	Deduct/Coins
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy **NYS & Federal Essential Health Benefit**	Platinum: $[25] copay per visit [redacted]	[redacted]	Deduct/Coins
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy **NYS & Federal Essential Health Benefit**	Platinum: $[25] copay per visit [redacted]	[redacted]	Deduct/Coins
Pulmonary Rehabilitation **NYS & Federal Essential Health Benefit**	PCP Copay	[redacted]	Deduct/Coins
Cardiac Rehabilitation **NYS & Federal Essential Health Benefit**	PCP Copay	[redacted]	Deduct/Coins
PHYSICIAN SERVICES		[redacted]	
Inpatient Hospital Surgery **NYS Essential Health Benefit**	Platinum: $[100] copay [redacted]	[redacted]	Deduct/Coins
Outpatient Hospital & Ambulatory Surgery **NYS Essential Health Benefit**	Platinum: $[100] copay [redacted]	[redacted]	Deduct/Coins
Office Surgery **NYS Essential Health Benefit**	PCP/Specialist Copay per visit	[redacted]	Deduct/Coins
Anesthesia **Includes IP, OP, OV and maternity** **NYS & Federal Essential Health Benefit**	Covered in Full, no Deductible	[redacted]	Deduct/Coins
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy **NYS & Federal Essential Health Benefit**	Platinum: $[25] copay per visit [redacted]	[redacted]	Deduct/Coins 60 visits per condition per lifetime
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy **NYS & Federal Essential Health Benefit**	Platinum: $[25] copay per visit [redacted]	[redacted]	Deduct/Coins

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		On Exchange	Off Exchange Rider
Benefit Type	**In-Network**	**Out-of-Network**	**Out-of-Network**
Additional Surgical Opinion **NYS & Federal Essential Health Benefit**	Specialist Copay		Deduct/Coins
Second Medical Opinion for Cancer **NYS & Federal Essential Health Benefit**	Specialist Copay		Deduct/Coins
Maternity Care: Normal, Complications & Termination. **NYS & Federal Essential Health Benefit**	Platinum: $[100] copay		Deduct/Coins
Prenatal Care **HCR Preventive Service** **NYS & Federal Essential Health Benefit**	Covered in full		Deduct/Coins
PHYSICIAN OFFICE - OTHER SERVICES			
Diagnostic & Routine Laboratory and Pathology	PCP/Specialist Copay		Deduct/Coins
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**	PCP/Specialist Copay		Deduct/Coins
Advanced Imaging Services **NYS & Federal Essential Health Benefit**	Specialist Copay		Deduct/Coins
Radiation Therapy **NYS & Federal Essential Health Benefit**	PCP copay		Deduct/Coins
Chemotherapy **NYS & Federal Essential Health Benefit**	PCP copay		Deduct/Coins
Infusion Therapy **NYS Essential Health Benefit**	PCP copay		Deduct/Coins
Dialysis (all forms) **NYS & Federal Essential Health Benefit**	PCP copay	Out of Area only: ar yr	Deduct/Coins
Mental Health Care **NYS & Federal Essential Health Benefit**	PCP Copay per visit Unlimited visits		Deduct/Coins Unlimited visits
Autism Applied Behavior Analysis **State Mandate** **NYS Essential Health Benefit**	PCP Copay per visit Limit of 680 hours per contract year		Deduct/Coins Limit of 680 hours per contract year
Substance Use Services **NYS & Federal Essential Health Benefit**	PCP Copay per visit Excludes family therapy.		Deduct/Coins Unlimited visits, Excludes family therapy.
Office Visits - Diagnostic **NYS & Federal Essential Health Benefit**	PCP/Specialist Copay		Deduct/Coins
Eye Exams - Diagnostic **NYS & Federal Essential Health Benefit**	PCP/Specialist Copay		Deduct/Coins
Hearing Evaluations Diagnostic **NYS & Federal Essential Health Benefit**	PCP/Specialist Copay		Deduct/Coins
Chiropractic Care **NYS & Federal Essential Health Benefit**	Specialist copay		Deduct/Coins
Office & Outpatient Consultations **NYS & Federal Essential Health Benefit**	PCP/Specialist Copay per visit		Deduct/Coins
Allergy Testing **NYS & Federal Essential Health Benefit**	PCP/Specialist Copay		Deduct/Coins
Allergy Treatment **Includes Serum and Injections** **NYS & Federal Essential Health Benefit**	PCP/Specialist Copay per visit		Deduct/Coins
Hearing Evaluations Routine **NYS Essential Health Benefit**	Specialist Copay		Deduct/Coins
Hearing Aids **NYS & Federal Essential Health Benefit**	Platinum: [10]% Coins		Deduct/50%Coins
PREVENTIVE SERVICES **Outpatient Facility & Professional Provider**			
Adult Physical Examinations **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	Covered in full		Deduct/Coins
Adult Immunizations **Federal HCR Preventive Service** **NYS Essential Health Benefit** **Federal Essential Health Benefit**	Covered in full		Deduct/Coins
Well Child Visits and Immunizations **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	Covered in full		Deduct/Coins
Routine Gynecological Exams **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	Covered in full		Deduct/Coins
Cervical Cytology Preventive only **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	Covered in full		Deduct/Coins

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		On Exchange	Off Exchange Rider
Benefit Type	**In-Network**	**Out-of-Network**	**Out-of-Network**
Mammogram Preventive only **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	Covered in full 1 per contract year	[redacted]	Deduct/Coins
Bone Density Testing **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	Covered in full when HCR Preventive PCP/Specialist Copay	[redacted]	Deduct/Coins
Colonoscopy Screening **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	Covered in full when HCR Preventive PCP/Specialist Copay	[redacted]	Deduct/Coins
Family Planning **HCR Preventive Service** **NYS & Federal Essential Health Benefit**	Covered in full when HCR Preventive PCP/Specialist Copay	[redacted]	Deduct/Coins
ADDITIONAL BENEFITS		[redacted]	
Treatment of Diabetes Insulin & Supplies **NYS & Federal Essential Health Benefit**	PCP copay	[redacted]	Deduct/Coins
Diabetic Education **NYS & Federal Essential Health Benefit**	PCP copay	[redacted]	Deduct/Coins
Diabetic Equipment **NYS & Federal Essential Health Benefit**	PCP copay	[redacted]	Deduct/Coins
Autism Assistive Communication Devices (ACD) **State Mandate** **NYS Essential Health Benefit**	PCP Copay per device	[redacted]	Deduct/Coins
Autologous Blood Banking **NYS Essential Health Benefit**	Platinum: [10]% Coins [redacted]	[redacted]	Deduct/50%Coins
Durable Medical Equipment (DME) **NYS & Federal Essential Health Benefit**	Platinum: [10]% Coins [redacted]	[redacted]	Deduct/50%Coins
External Prosthetics **NYS & Federal Essential Health Benefit**	Platinum: [10]% Coins [redacted]	[redacted]	Deduct/50%Coins
Orthotics **Foot orthotics included**	Not Covered	[redacted]	Not Covered
Medical Supplies **NYS & Federal Essential Health Benefit**	Platinum: [10]% Coins [redacted]	[redacted]	Deduct/50%Coins
HEALTH & WELLNESS **Incentive Programs** **NYS & Federal Essential Health Benefit**	Gym Membership Reimbursement $200 for member; $100 for spouse Not subject to Deductible Once every 6 months	[redacted]	Gym Membership Reimbursement $200 for member; $100 for spouse Not subject to Deductible Once every 6 months
EMERGENCY SERVICES **Emergency Condition**		[redacted]	
Facility – Emergency Room **NYS & Federal Essential Health Benefit**	Platinum: $[100] copay [redacted]	[redacted]	Platinum: $[100] copay Gold: $[150] Silver: $[150] Silver CSR: $[50; 75; 150]
Physician's Hospital Emergency Room Visit **NYS & Federal Essential Health Benefit**	Covered in full	[redacted]	Covered in full
Prehospital Emergency Services/Transportation **NYS & Federal Essential Health Benefit**	Platinum: $[100] copay [redacted]	[redacted]	Platinum: $[100] copay Gold: $[150] Silver: $[150] Silver CSR: $[50; 75; 150]
Freestanding Urgent Care Center **Art 28 Facility** **NYS & Federal Essential Health Benefit**	Platinum: $55 copay [redacted]	[redacted]	Deduct/Coins
Physician's Freestanding Urgent Care Center (Art 28 Facility) **NYS & Federal Essential Health Benefit**	$0 Copay	[redacted]	Deduct/Coins
Physician Urgent Care Office Visit **NYS & Federal Essential Health Benefit**	See office visit benefit	[redacted]	See office visit benefit
VISION BENEFITS		[redacted]	
Eye Exams Routine - Adults	Not Covered	[redacted]	Not Covered
Eyewear - Adults	Not Covered	[redacted]	Not Covered
Eye Exams Routine - Pediatric **NYS & Federal Essential Health Benefit**	PCP Copay	[redacted]	Deduct/Coins

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		On Exchange	Off Exchange Rider
Benefit Type	**In-Network**	**Out-of-Network**	**Out-of-Network**
Eyewear - Pediatric **NYS & Federal Essential Health Benefit**	Platinum: [10]% Coins [redacted]	[redacted]	Deduct/[50]% Coins
DENTAL BENEFITS			
Adult Dental	Not Covered	[redacted]	Not Covered
Pediatric Dental - Emergency Care **NYS & Federal Essential Health Benefit**	PCP Copay	[redacted]	PCP Copay
Pediatric Dental - Preventive **NYS & Federal Essential Health Benefit**	PCP Copay	[redacted]	PCP Copay
Pediatric Dental - Routine **NYS & Federal Essential Health Benefit**	PCP copay	[redacted]	PCP Copay
Pediatric Dental - Endodontic **NYS & Federal Essential Health Benefit**	PCP Copay	[redacted]	PCP Copay
Pediatric Dental - Prosthodontics **NYS & Federal Essential Health Benefit**	PCP Copay	[redacted]	PCP Copay
Pediatric Dental - Orthodontics **NYS & Federal Essential Health Benefit**	PCP Copay	[redacted]	PCP Copay
PRESCRIPTION DRUGS **Closed Formulary**			
Generic or Tier 1/Tier 2/Tier 3 **NYS & Federal Essential Health Benefit**	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90 day supply	[redacted]	
Platinum	Copay: $10 /$30/$60	[redacted]	Not Covered
Gold	Copay: $10 /$35/$70	[redacted]	Not Covered
Silver	Copay: $10 /$35/$70	[redacted]	Not Covered
Silver 200-250 FPL	Copay: $10 /$35/$70	[redacted]	Not Covered
Silver 150-200 FPL	Copay: $8 /$20/$40	[redacted]	Not Covered
Silver 100-150 FPL	Copay: $6/$15/$30	[redacted]	Not Covered
Native American 300 FPL	$0 all tiers	[redacted]	Not Covered
Bronze	Deductible Copay: $10 /$35/$70	[redacted]	Not Covered
Catastrophic	Deduct/Coins	[redacted]	Not Covered
WAITING PERIODS	None		
EXCLUSIONS	Standard Exclusions apply		

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Benefit Type	In-Network	Out-of-Network
PROVIDER NETWORK & SERVICE AREA		
Provider Network Counties - BCBS	BCBS 31 counties only	
Provider Network Counties - Univera	**39 Counties: BCBS 31 plus Univera 8**	
BCBS Service Area	**Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson**	
Univera Service Area	**Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming.**	
WHO IS COVERED		
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage **Federal Mandate**	26 to end of month of birthday	
Domestic Partner Coverage	Covered - standard	
COST SHARING EXPENSES		
Contract Year	Calendar Year	
Deductible **· Single/ Family**	[redacted]	
4th Quarter Deductible Carry-Over Y/N	[redacted]	
Copayment	[redacted]	
Coinsurance	[redacted]	
Annual Out-of-Pocket Maximum	[redacted]	
Annual Benefit Maximum **Federal Mandate**	[redacted]	
Lifetime Benefit Maximum **Federal Mandate**	[redacted]	
HOSPITAL INPATIENT SERVICES	[redacted]	
Inpatient Hospital Services **NYS & Federal Essential Health Benefit**	[redacted]	
Mental Health Care **NYS & Federal Essential Health Benefit**	[redacted]	
Residential Treatment	[redacted]	
Substance Use Detoxification **NYS & Federal Essential Health Benefit**	[redacted]	
Substance Use Rehabilitation **NYS & Federal Essential Health Benefit**	[redacted]	
Skilled Nursing Facility **NYS & Federal Essential Health Benefit**	[redacted]	
Physical Rehabilitation **includes habilitative services** **NYS & Federal Essential Health Benefit**	[redacted]	
Maternity Care **NYS & Federal Essential Health Benefit**	[redacted]	
Maternity Care – Routine Newborn Nursery **NYS & Federal Essential Health Benefit**	[redacted]	
Implanted Devices **NYS & Federal Essential Health Benefit**	[redacted]	
End of Life Care **State Mandate** **NYS Essential Health Benefit**	[redacted]	
Observation Stay **NYS & Federal Essential Health Benefit**	[redacted]	
HOME CARE **NYS & Federal Essential Health Benefit**	[redacted]	
HOSPITAL OUTPATIENT SERVICES	[redacted]	
Surgical Care including Surgicenters & Freestanding Facilities **NYS & Federal Essential Health Benefit**	[redacted]	
Pre-admission/Pre-Operative Testing **NYS & Federal Essential Health Benefit**	[redacted]	
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**	[redacted]	
Advanced Imaging Services **NYS & Federal Essential Health Benefit**	[redacted]	

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Benefit Type	In-Network	Out-of-Network
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Radiation Therapy NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Chemotherapy NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Infusion Therapy NYS Essential Health Benefit	[redacted]	[redacted]
Dialysis (all forms) NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Mental Health Care NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	[redacted]	[redacted]
Substance Use Services NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Cardiac Rehabilitation NYS & Federal Essential Health Benefit	[redacted]	[redacted]
PHYSICIAN SERVICES	[redacted]	[redacted]
Inpatient Hospital Surgery NYS Essential Health Benefit	[redacted]	[redacted]
Outpatient Hospital & Ambulatory Surgery NYS Essential Health Benefit	[redacted]	[redacted]
Office Surgery NYS Essential Health Benefit	[redacted]	[redacted]
Anesthesia Includes IP, OP, OV and maternity NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Additional Surgical Opinion NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Second Medical Opinion for Cancer NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Maternity Care: Normal, Complications & Termination. NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Prenatal Care HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
PHYSICIAN OFFICE - OTHER SERVICES	[redacted]	[redacted]
Diagnostic & Routine Laboratory and Pathology	[redacted]	[redacted]
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Advanced Imaging Services NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Radiation Therapy NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Chemotherapy NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Infusion Therapy NYS Essential Health Benefit	[redacted]	[redacted]
Dialysis (all forms) NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Mental Health Care NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	[redacted]	[redacted]

Excellus Health Plan, Inc.
Excellus BCBS; Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Benefit Descriptions

EXEC-1 (Exclusive Provider Organization);
EXEC-2 (Exclusive Provider Organization Child Only);
EXEC-3 (Exclusive Provider Organization, Catastrophic Plan);
Bronze & Catastrophic Standard
NYS Benchmark Plan
Individual

Benefit Type	In-Network	Out-of-Network
Substance Use Services NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Office Visits - Diagnostic NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Eye Exams - Diagnostic NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Hearing Evaluations Diagnostic NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Chiropractic Care NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Office & Outpatient Consultations NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Allergy Testing NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Allergy Treatment Includes Serum and Injections NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Hearing Evaluations Routine NYS Essential Health Benefit	[redacted]	[redacted]
Hearing Aids NYS & Federal Essential Health Benefit	[redacted]	[redacted]
PREVENTIVE SERVICES Outpatient Facility & Professional Provider	[redacted]	[redacted]
Adult Physical Examinations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Adult Immunizations Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit	[redacted]	[redacted]
Well Child Visits and Immunizations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Routine Gynecological Exams Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Cervical Cytology Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Prostate Cancer Screenings Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Mammogram Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Bone Density Testing Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Colonoscopy Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Family Planning HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	[redacted]
ADDITIONAL BENEFITS	[redacted]	[redacted]
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Diabetic Education NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Diabetic Equipment NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit	[redacted]	[redacted]
Autologous Blood Banking NYS Essential Health Benefit	[redacted]	[redacted]
Durable Medical Equipment (DME) NYS & Federal Essential Health Benefit	[redacted]	[redacted]
External Prosthetics NYS & Federal Essential Health Benefit	[redacted]	[redacted]

Excellus Health Plan, Inc.
Excellus BCBS; Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Benefit Descriptions

EXEC-1 (Exclusive Provider Organization);
EXEC-2 (Exclusive Provider Organization Child Only);
EXEC-3 (Exclusive Provider Organization, Catastrophic Plan);
Bronze & Catastrophic Standard
NYS Benchmark Plan
Individual

Benefit Type	In-Network	Out-of-Network
Orthotics Foot orthotics included	[redacted]	[redacted]
Medical Supplies NYS & Federal Essential Health Benefit	[redacted]	[redacted]
HEALTH & WELLNESS Incentive Programs NYS & Federal Essential Health Benefit	[redacted]	[redacted]
EMERGENCY SERVICES Emergency Condition	[redacted]	[redacted]
Facility – Emergency Room NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Physician's Hospital Emergency Room Visit NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Prehospital Emergency Services/Transportation NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Freestanding Urgent Care Center Art 28 Facility NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Physician's Freestanding Urgent Care Center (Art 28 Facility) NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Physician Urgent Care Office Visit NYS & Federal Essential Health Benefit	[redacted]	[redacted]
VISION BENEFITS	[redacted]	[redacted]
Eye Exams Routine - Adults	[redacted]	[redacted]
Eyewear - Adults	[redacted]	[redacted]
Eye Exams Routine - Pediatric NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Eyewear - Pediatric NYS & Federal Essential Health Benefit	[redacted]	[redacted]
DENTAL BENEFITS	[redacted]	[redacted]
Adult Dental	[redacted]	[redacted]
Pediatric Dental - Emergency Care NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Pediatric Dental - Routine NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	[redacted]	[redacted]
PRESCRIPTION DRUGS Closed Formulary	[redacted]	[redacted]
Generic or Tier 1/Tier 2/Tier 3 NYS & Federal Essential Health Benefit	[redacted]	[redacted]
Bronze	[redacted]	[redacted]
Catastrophic	[redacted]	[redacted]
WAITING PERIODS	[redacted]	[redacted]
EXCLUSIONS	[redacted]	[redacted]

Excellus Health Plan, Inc.
Excellus BCBS; Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Benefit Descriptions

EXEC-1 (Exclusive Provider Organization);
Platinum Non-Standard
Individual

Benefit Type	In-Network	Out-of-Network
PROVIDER NETWORK & SERVICE AREA		
Provider Network Counties - BCBS	BCBS 31 counties only	
Provider Network Counties - Univera	**39 Counties: BCBS 31 plus Univera 8**	
BCBS Service Area	**Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson**	
Univera Service Area	**Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming;**	
WHO IS COVERED		
Type of Tiers – 4 Tier	Single - Subscriber 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage **Federal Mandate**	26 to end of month of birthday	
Domestic Partner Coverage	Covered - standard	
COST SHARING EXPENSES		
Contract Year	Calendar Year	
Deductible **· Single/ Family**	[redacted]	
4th Quarter Deductible Carry-Over Y/N		
Copayment		
Coinsurance		
Annual Out-of-Pocket Maximum		
Annual Benefit Maximum **Federal Mandate**		
Lifetime Benefit Maximum **Federal Mandate**		
HOSPITAL INPATIENT SERVICES		
Inpatient Hospital Services **NYS & Federal Essential Health Benefit**		
Mental Health Care **NYS & Federal Essential Health Benefit**		
Residential Treatment		
Substance Use Detoxification **NYS & Federal Essential Health Benefit**		
Substance Use Rehabilitation **NYS & Federal Essential Health Benefit**		
Skilled Nursing Facility **NYS & Federal Essential Health Benefit**		
Physical Rehabilitation **includes habilitative services** **NYS & Federal Essential Health Benefit**		
Maternity Care **NYS & Federal Essential Health Benefit**		
Maternity Care – Routine Newborn Nursery **NYS & Federal Essential Health Benefit**		
Implanted Devices **NYS & Federal Essential Health Benefit**		
End of Life Care **State Mandate** **NYS Essential Health Benefit**		
Observation Stay **NYS & Federal Essential Health Benefit**		
HOME CARE **NYS & Federal Essential Health Benefit**		
[redacted]		
HOSPITAL OUTPATIENT SERVICES		
Surgical Care including Surgicenters & Freestanding Facilities **NYS & Federal Essential Health Benefit**		
Pre-admission/Pre-Operative Testing **NYS & Federal Essential Health Benefit**		
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**		
Advanced Imaging Services **NYS & Federal Essential Health Benefit**		
Diagnostic & Routine Laboratory and Pathology **NYS & Federal Essential Health Benefit**		

2014 Individual Benefit Descriptions

EXEC-1 (Exclusive Provider Organization);
Platinum Non-Standard
Individual

Benefit Type	In-Network	Out-of-Network
Radiation Therapy NYS & Federal Essential Health Benefit	[redacted]	
Chemotherapy NYS & Federal Essential Health Benefit	[redacted]	
Infusion Therapy NYS Essential Health Benefit	[redacted]	
Dialysis (all forms) NYS & Federal Essential Health Benefit	[redacted]	
Mental Health Care NYS & Federal Essential Health Benefit	[redacted]	
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	[redacted]	
Substance Use Services NYS & Federal Essential Health Benefit	[redacted]	
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	[redacted]	
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	[redacted]	
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	[redacted]	
Cardiac Rehabilitation NYS & Federal Essential Health Benefit	[redacted]	
PHYSICIAN SERVICES	[redacted]	
Inpatient Hospital Surgery NYS Essential Health Benefit	[redacted]	
Outpatient Hospital & Ambulatory Surgery NYS Essential Health Benefit	[redacted]	
Office Surgery NYS Essential Health Benefit	[redacted]	
Anesthesia Includes IP, OP, OV and maternity NYS & Federal Essential Health Benefit	[redacted]	
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	[redacted]	
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	[redacted]	
Additional Surgical Opinion NYS & Federal Essential Health Benefit	[redacted]	
Second Medical Opinion for Cancer NYS & Federal Essential Health Benefit	[redacted]	
Maternity Care: Normal, Complications & Termination. NYS & Federal Essential Health Benefit	[redacted]	
Prenatal Care HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
PHYSICIAN OFFICE - OTHER SERVICES	[redacted]	
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	[redacted]	
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	[redacted]	
Advanced Imaging Services NYS & Federal Essential Health Benefit	[redacted]	
Radiation Therapy NYS & Federal Essential Health Benefit	[redacted]	
Chemotherapy NYS & Federal Essential Health Benefit	[redacted]	
Infusion Therapy NYS Essential Health Benefit	[redacted]	
Dialysis (all forms) NYS & Federal Essential Health Benefit	[redacted]	
Mental Health Care NYS & Federal Essential Health Benefit	[redacted]	
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	[redacted]	
Substance Use Services NYS & Federal Essential Health Benefit	[redacted]	

Excellus Health Plan, Inc.
Excellus BCBS; Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Benefit Descriptions

EXEC-1 (Exclusive Provider Organization);
Platinum Non-Standard
Individual

Benefit Type	In-Network	Out-of-Network
Office Visits - Diagnostic NYS & Federal Essential Health Benefit	[redacted]	
Medications Administered in Office NYS & Federal Essential Health Benefit	[redacted]	
Eye Exams - Diagnostic NYS & Federal Essential Health Benefit	[redacted]	
Hearing Evaluations Diagnostic NYS & Federal Essential Health Benefit	[redacted]	
Chiropractic Care NYS & Federal Essential Health Benefit	[redacted]	
Office & Outpatient Consultations NYS & Federal Essential Health Benefit	[redacted]	
Allergy Testing NYS & Federal Essential Health Benefit	[redacted]	
Allergy Treatment Includes Serum and Injections NYS & Federal Essential Health Benefit	[redacted]	
Hearing Evaluations Routine NYS Essential Health Benefit	[redacted]	
Hearing Aids NYS & Federal Essential Health Benefit	[redacted]	
PREVENTIVE SERVICES Outpatient Facility & Professional Provider	[redacted]	
Adult Physical Examinations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
Adult Immunizations Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit	[redacted]	
Well Child Visits and Immunizations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
Routine Gynecological Exams Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
Cervical Cytology Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
Prostate Cancer Screenings Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
Mammogram Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
Bone Density Testing Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
Colonoscopy Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
Family Planning HCR Preventive Service NYS & Federal Essential Health Benefit	[redacted]	
ADDITIONAL BENEFITS	[redacted]	
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	[redacted]	
Diabetic Education NYS & Federal Essential Health Benefit	[redacted]	
Diabetic Equipment NYS & Federal Essential Health Benefit	[redacted]	
Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit	[redacted]	
Autologous Blood Banking NYS Essential Health Benefit	[redacted]	
Durable Medical Equipment (DME) NYS & Federal Essential Health Benefit	[redacted]	
External Prosthetics NYS & Federal Essential Health Benefit	[redacted]	
Orthotics Foot orthotics included	[redacted]	
Medical Supplies NYS & Federal Essential Health Benefit	[redacted]	

Excellus Health Plan, Inc.
Excellus BCBS; Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Benefit Descriptions

EXEC-1 (Exclusive Provider Organization);
Platinum Non-Standard
Individual

Benefit Type	In-Network	Out-of-Network
HEALTH & WELLNESS Incentive Programs NYS & Federal Essential Health Benefit	[redacted]	
EMERGENCY SERVICES	[redacted]	
Facility – Emergency Room NYS & Federal Essential Health Benefit	[redacted]	
Physician's Hospital Emergency Room Visit NYS & Federal Essential Health Benefit	[redacted]	
Prehospital Emergency Services/Transportation NYS & Federal Essential Health Benefit	[redacted]	
Freestanding Urgent Care Center Art 28 Facility NYS & Federal Essential Health Benefit	[redacted]	
Physician's Freestanding Urgent Care Center (Art 28 Facility) NYS & Federal Essential Health Benefit	[redacted]	
Physician Urgent Care Office Visit NYS & Federal Essential Health Benefit	[redacted]	
VISION BENEFITS	[redacted]	
Eye Exams Routine - Adults	[redacted]	
Eyewear - Adults	[redacted]	
Eye Exams Routine - Pediatric NYS & Federal Essential Health Benefit	[redacted]	
Eyewear - Pediatric NYS & Federal Essential Health Benefit	[redacted]	
DENTAL BENEFITS	[redacted]	
Adult Dental	[redacted]	
Pediatric Dental - Emergency Care NYS & Federal Essential Health Benefit	[redacted]	
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	[redacted]	
Pediatric Dental - Routine NYS & Federal Essential Health Benefit	[redacted]	
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	[redacted]	
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	[redacted]	
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	[redacted]	
PRESCRIPTION DRUGS	[redacted]	
Generic or Tier 1/Tier 2/Tier 3 NYS & Federal Essential Health Benefit	[redacted]	
Platinum	[redacted]	
WAITING PERIODS	[redacted]	
EXCLUSIONS	[redacted]	

Excellus Health Plan, Inc.
Excellus BCBS; Univera Healthcare

Effective Date: January 1, 2014
Community Rated

2014 Individual Benefit Descriptions

EXEC-1 (Exclusive Provider Organization)
Hybrid A Plans Non-Standard
Individual - Gold

Benefit Type	In-Network	Out-of-Network
PROVIDER NETWORK & SERVICE AREA		
Provider Network Counties - BCBS	**BCBS 31 counties only**	
Provider Network Counties - Univera	**39 Counties: BCBS 31 plus Univera 8**	
BCBS Service Area	**Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson**	
Univera Service Area	**Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming;**	
WHO IS COVERED		
Type of Tiers – 4 Tier	Single - Subscriber 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage **Federal Mandate**	26 to end of month of birthday	
Domestic Partner Coverage	Covered - standard	
COST SHARING EXPENSES		
Contract Year	Calendar Year	
Deductible **· Single/ Family**	[redacted]	
4th Quarter Deductible Carry-Over Y/N		
Copayment		
Coinsurance		
Annual Out-of-Pocket Maximum		
Annual Benefit Maximum **Federal Mandate**		
Lifetime Benefit Maximum **Federal Mandate**		
HOSPITAL INPATIENT SERVICES		
Inpatient Hospital Services **NYS & Federal Essential Health Benefit**		
Mental Health Care **NYS & Federal Essential Health Benefit**		
Residential Treatment		
Substance Use Detoxification **NYS & Federal Essential Health Benefit**		
Substance Use Rehabilitation **NYS & Federal Essential Health Benefit**		
Skilled Nursing Facility **NYS & Federal Essential Health Benefit**		
Physical Rehabilitation **includes habilitative services** **NYS & Federal Essential Health Benefit**		
Maternity Care **NYS & Federal Essential Health Benefit**		
Maternity Care – Routine Newborn Nursery **NYS & Federal Essential Health Benefit**		
Implanted Devices **NYS & Federal Essential Health Benefit**		
End of Life Care **State Mandate** **NYS Essential Health Benefit**		
Observation Stay **NYS & Federal Essential Health Benefit**		
HOME CARE **NYS & Federal Essential Health Benefit**		
HOSPICE CARE **NYS & Federal Essential Health Benefit**		
HOSPITAL OUTPATIENT SERVICES		
Surgical Care including Surgicenters & Freestanding Facilities **NYS & Federal Essential Health Benefit**		
Pre-admission/Pre-Operative Testing **NYS & Federal Essential Health Benefit**		
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**		
Advanced Imaging Services **NYS & Federal Essential Health Benefit**		
Diagnostic & Routine Laboratory and Pathology **NYS & Federal Essential Health Benefit**		

2014 Individual Benefit Descriptions

Radiation Therapy **NYS & Federal Essential Health Benefit**	[redacted]		
Chemotherapy **NYS & Federal Essential Health Benefit**			
Infusion Therapy **NYS Essential Health Benefit**			
Dialysis (all forms) **NYS & Federal Essential Health Benefit** **Mental Health Care** **NYS & Federal Essential Health Benefit**			
Autism Applied Behavior Analysis **State Mandate** **NYS Essential Health Benefit**			
Substance Use Services **NYS & Federal Essential Health Benefit**			
Covered Therapies - Rehabilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**			
Covered Therapies - Habilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**			
Pulmonary Rehabilitation **NYS & Federal Essential Health Benefit**			
Cardiac Rehabilitation **NYS & Federal Essential Health Benefit**			
PHYSICIAN SERVICES			
Inpatient Hospital Surgery **NYS Essential Health Benefit**			
Outpatient Hospital & Ambulatory Surgery **NYS Essential Health Benefit**			
Office Surgery **NYS Essential Health Benefit**			
Anesthesia **Includes IP, OP, OV and maternity** **NYS & Federal Essential Health Benefit**			
Covered Therapies - Rehabilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**			
Covered Therapies - Habilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**			
Additional Surgical Opinion **NYS & Federal Essential Health Benefit**			
Second Medical Opinion for Cancer **NYS & Federal Essential Health Benefit**			cost
Maternity Care: Normal, Complications & Termination. **NYS & Federal Essential Health Benefit**			
Prenatal Care **HCR Preventive Service** **NYS & Federal Essential Health Benefit**			
PHYSICIAN OFFICE - OTHER SERVICES			
Diagnostic & Routine Laboratory and Pathology **NYS & Federal Essential Health Benefit**			
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**			
Advanced Imaging Services **NYS & Federal Essential Health Benefit**			
Radiation Therapy **NYS & Federal Essential Health Benefit**			
Chemotherapy **NYS & Federal Essential Health Benefit**			
Infusion Therapy **NYS Essential Health Benefit**			
Dialysis (all forms) **NYS & Federal Essential Health Benefit**			
Mental Health Care **NYS & Federal Essential Health Benefit**			
Autism Applied Behavior Analysis **State Mandate** **NYS Essential Health Benefit**			
Substance Use Services **NYS & Federal Essential Health Benefit**			
Office Visits - Diagnostic **NYS & Federal Essential Health Benefit**			
Medications Administered in Office **NYS & Federal Essential Health Benefit**			
Eye Exams - Diagnostic **NYS & Federal Essential Health Benefit**			

2014 Individual Benefit Descriptions

Hearing Evaluations Diagnostic **NYS & Federal Essential Health Benefit**	[redacted]	
Chiropractic Care **NYS & Federal Essential Health Benefit**	[redacted]	
Office & Outpatient Consultations **NYS & Federal Essential Health Benefit**	[redacted]	
Allergy Testing **NYS & Federal Essential Health Benefit**	[redacted]	
Allergy Treatment **Includes Serum and Injections** **NYS & Federal Essential Health Benefit**	[redacted]	
Hearing Evaluations Routine **NYS Essential Health Benefit**	[redacted]	
Hearing Aids **NYS & Federal Essential Health Benefit**	[redacted]	
PREVENTIVE SERVICES **Outpatient Facility & Professional Provider**	[redacted]	
Adult Physical Examinations **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
Adult Immunizations **Federal HCR Preventive Service** **NYS Essential Health Benefit** **Federal Essential Health Benefit**	[redacted]	
Well Child Visits and Immunizations **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
Routine Gynecological Exams **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
Cervical Cytology Preventive only **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
Prostate Cancer Screenings **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
Mammogram Preventive only **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
Bone Density Testing **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
Colonoscopy Screening **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
Family Planning **HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
ADDITIONAL BENEFITS	[redacted]	
Treatment of Diabetes Insulin & Supplies **NYS & Federal Essential Health Benefit**	[redacted]	
Diabetic Education **NYS & Federal Essential Health Benefit**	[redacted]	
Diabetic Equipment **NYS & Federal Essential Health Benefit**	[redacted]	
Autism Assistive Communication Devices (ACD) **State Mandate** **NYS Essential Health Benefit**	[redacted]	
Autologous Blood Banking **NYS Essential Health Benefit**	[redacted]	
Durable Medical Equipment (DME) **NYS & Federal Essential Health Benefit**	[redacted]	
External Prosthetics **NYS & Federal Essential Health Benefit**	[redacted]	
Orthotics **Foot orthotics included**	[redacted]	
Medical Supplies **NYS & Federal Essential Health Benefit**	[redacted]	
HEALTH & WELLNESS **Incentive Programs** **NYS & Federal Essential Health Benefit**	[redacted]	
EMERGENCY SERVICES **Emergency Condition**	[redacted]	
Facility – Emergency Room **NYS & Federal Essential Health Benefit**	[redacted]	
Physician's Hospital Emergency Room Visit **NYS & Federal Essential Health Benefit**	[redacted]	
Prehospital Emergency Services/Transportation **NYS & Federal Essential Health Benefit**	[redacted]	

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2014 Individual Benefit Descriptions

Freestanding Urgent Care Center **Art 28 Facility** **NYS & Federal Essential Health Benefit**	[redacted]		
Physician's Freestanding Urgent Care Center (Art 28 Facility) **NYS & Federal Essential Health Benefit**			
Physician Urgent Care Office Visit **NYS & Federal Essential Health Benefit**			
VISION BENEFITS			
Eye Exams Routine - Adults			
Eyewear - Adults			
Eye Exams Routine - Pediatric **NYS & Federal Essential Health Benefit**			
Eyewear - Pediatric **NYS & Federal Essential Health Benefit**			
DENTAL BENEFITS			
Adult Dental			
Pediatric Dental - Emergency Care **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Preventive **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Routine **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Endodontic **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Prosthodontics **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Orthodontics **NYS & Federal Essential Health Benefit**			
PRESCRIPTION DRUGS **Closed Formulary**			
Generic or Tier 1/Tier 2/Tier 3 **NYS & Federal Essential Health Benefit**	[redacted]		
Gold			
WAITING PERIODS			
EXCLUSIONS			

2014 Individual Benefit Descriptions

EXEC-1
HDHP Plans Non-Standard
Individual - [Silver; Bronze]

Benefit Type	In-Network	Out-of-Network
PROVIDER NETWORK & SERVICE AREA		
Provider Network Counties - BCBS	BCBS 31 counties only	
Provider Network Counties - Univera	**39 Counties: BCBS 31 plus Univera 8**	
BCBS Service Area	**Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson**	
Univera Service Area	**Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming;**	
WHO IS COVERED		
Type of Tiers – 4 Tier	Single - Subscriber 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage **Federal Mandate**	26 to end of month of birthday	
Domestic Partner Coverage	Covered - standard	
COST SHARING EXPENSES		
Contract Year	Calendar Year	
Deductible **· Single/ Family**	[redacted]	
4th Quarter Deductible Carry-Over Y/N	[redacted]	
Copayment	[redacted]	
Coinsurance	[redacted]	
Annual Out-of-Pocket Maximum	[redacted]	
Annual Benefit Maximum **Federal Mandate**	[redacted]	
Lifetime Benefit Maximum **Federal Mandate**	[redacted]	
HOSPITAL INPATIENT SERVICES	[redacted]	
Inpatient Hospital Services **NYS & Federal Essential Health Benefit**	[redacted]	
Mental Health Care **NYS & Federal Essential Health Benefit**	[redacted]	
Residential Treatment	[redacted]	
Substance Use Detoxification **NYS & Federal Essential Health Benefit**	[redacted]	
Substance Use Rehabilitation **NYS & Federal Essential Health Benefit**	[redacted]	
Skilled Nursing Facility **NYS & Federal Essential Health Benefit**	[redacted]	
Physical Rehabilitation **includes habilitative services** **NYS & Federal Essential Health Benefit**	[redacted]	
Maternity Care **NYS & Federal Essential Health Benefit**	[redacted]	
Maternity Care – Routine Newborn Nursery **NYS & Federal Essential Health Benefit**	[redacted]	
Implanted Devices **NYS & Federal Essential Health Benefit**	[redacted]	
End of Life Care **State Mandate** **NYS Essential Health Benefit**	[redacted]	
Observation Stay **NYS & Federal Essential Health Benefit**	[redacted]	
HOME CARE **NYS & Federal Essential Health Benefit**	[redacted]	
HOSPICE CARE **NYS & Federal Essential Health Benefit**	[redacted]	
HOSPITAL OUTPATIENT SERVICES	[redacted]	
Surgical Care including Surgicenters & Freestanding Facilities **NYS & Federal Essential Health Benefit**	[redacted]	
Pre-admission/Pre-Operative Testing **NYS & Federal Essential Health Benefit**	[redacted]	
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**	[redacted]	

2014 Individual Benefit Descriptions

Advanced Imaging Services **NYS & Federal Essential Health Benefit**	[redacted]		
Diagnostic & Routine Laboratory and Pathology **NYS & Federal Essential Health Benefit**	[redacted]		
Radiation Therapy **NYS & Federal Essential Health Benefit**	[redacted]		
Chemotherapy **NYS & Federal Essential Health Benefit**	[redacted]		
Infusion Therapy **NYS Essential Health Benefit**	[redacted]		
Dialysis (all forms) **NYS & Federal Essential Health Benefit**	[redacted]		y:
Mental Health Care **NYS & Federal Essential Health Benefit**	[redacted]		
Autism Applied Behavior Analysis **State Mandate** **NYS Essential Health Benefit**	[redacted]		
Substance Use Services **NYS & Federal Essential Health Benefit**	[redacted]		
Covered Therapies - Rehabilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**	[redacted]		
Covered Therapies - Habilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**	[redacted]		
Pulmonary Rehabilitation **NYS & Federal Essential Health Benefit**	[redacted]		
Cardiac Rehabilitation **NYS & Federal Essential Health Benefit**	[redacted]		
PHYSICIAN SERVICES	[redacted]		
Inpatient Hospital Surgery **NYS Essential Health Benefit**	[redacted]		
Outpatient Hospital & Ambulatory Surgery **NYS Essential Health Benefit**	[redacted]		
Office Surgery **NYS Essential Health Benefit**	[redacted]		
Anesthesia **Includes IP, OP, OV and maternity** **NYS & Federal Essential Health Benefit**	[redacted]		
Covered Therapies - Rehabilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**	[redacted]		
Covered Therapies - Habilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**	[redacted]		
Additional Surgical Opinion **NYS & Federal Essential Health Benefit**	[redacted]		
Second Medical Opinion for Cancer **NYS & Federal Essential Health Benefit**	[redacted]		etwork AE & cost
Maternity Care: Normal, Complications & Termination. **NYS & Federal Essential Health Benefit**	[redacted]		
Prenatal Care **HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
PHYSICIAN OFFICE - OTHER SERVICES	[redacted]		
Diagnostic & Routine Laboratory and Pathology **NYS & Federal Essential Health Benefit**	[redacted]		
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**	[redacted]		
Advanced Imaging Services **NYS & Federal Essential Health Benefit**	[redacted]		
Radiation Therapy **NYS & Federal Essential Health Benefit**	[redacted]		
Chemotherapy **NYS & Federal Essential Health Benefit**	[redacted]		
Infusion Therapy **NYS Essential Health Benefit**	[redacted]		
Dialysis (all forms) **NYS & Federal Essential Health Benefit**	[redacted]		y:
Mental Health Care **NYS & Federal Essential Health Benefit**	[redacted]		
Autism Applied Behavior Analysis **State Mandate** **NYS Essential Health Benefit**	[redacted]		
Substance Use Services **NYS & Federal Essential Health Benefit**	[redacted]		
Office Visits - Diagnostic **NYS & Federal Essential Health Benefit**	[redacted]		
Medications Administered in Office **NYS & Federal Essential Health Benefit**	[redacted]		
Eye Exams - Diagnostic **NYS & Federal Essential Health Benefit**	[redacted]		
Hearing Evaluations Diagnostic **NYS & Federal Essential Health Benefit**	[redacted]		
Chiropractic Care **NYS & Federal Essential Health Benefit**	[redacted]		

2014 Individual Benefit Descriptions

Office & Outpatient Consultations **NYS & Federal Essential Health Benefit**	[redacted]		
Allergy Testing **NYS & Federal Essential Health Benefit**	[redacted]		
Allergy Treatment **Includes Serum and Injections** **NYS & Federal Essential Health Benefit**	[redacted]		
Hearing Evaluations Routine **NYS Essential Health Benefit**	[redacted]		
Hearing Aids **NYS & Federal Essential Health Benefit**	[redacted]		
PREVENTIVE SERVICES	[redacted]		
Adult Physical Examinations **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
Adult Immunizations **Federal HCR Preventive Service** **NYS Essential Health Benefit** **Federal Essential Health Benefit**	[redacted]		
Well Child Visits and Immunizations **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
Routine Gynecological Exams **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
Cervical Cytology Preventive only **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
Prostate Cancer Screenings **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
Mammogram Preventive only **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
Bone Density Testing **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
Colonoscopy Screening **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
Family Planning **HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]		
ADDITIONAL BENEFITS	[redacted]		
Treatment of Diabetes Insulin & Supplies **NYS & Federal Essential Health Benefit**	[redacted]		
Diabetic Education **NYS & Federal Essential Health Benefit**	[redacted]		
Diabetic Equipment **NYS & Federal Essential Health Benefit**	[redacted]		
Autism Assistive Communication Devices (ACD) **State Mandate** **NYS Essential Health Benefit**	[redacted]		
Autologous Blood Banking **NYS Essential Health Benefit**	[redacted]		
Durable Medical Equipment (DME) **NYS & Federal Essential Health Benefit**	[redacted]		
External Prosthetics **NYS & Federal Essential Health Benefit**	[redacted]		
Orthotics **Foot orthotics included**	[redacted]		
Medical Supplies **NYS & Federal Essential Health Benefit**	[redacted]		
HEALTH & WELLNESS **Incentive Programs** **NYS & Federal Essential Health Benefit**	[redacted]		
EMERGENCY SERVICES	[redacted]		
Facility – Emergency Room **NYS & Federal Essential Health Benefit**	[redacted]		
Physician's Hospital Emergency Room Visit **NYS & Federal Essential Health Benefit**	[redacted]		
Prehospital Emergency Services/Transportation **NYS & Federal Essential Health Benefit**	[redacted]		
Freestanding Urgent Care Center **Art 28 Facility** **NYS & Federal Essential Health Benefit**	[redacted]		
Physician's Freestanding Urgent Care Center (Art 28 Facility) **NYS & Federal Essential Health Benefit**	[redacted]		
Physician Urgent Care Office Visit **NYS & Federal Essential Health Benefit**	[redacted]		
VISION BENEFITS	[redacted]		
Eye Exams Routine - Adults	[redacted]		
Eyewear - Adults	[redacted]		
Eye Exams Routine - Pediatric **NYS & Federal Essential Health Benefit**	[redacted]		

2014 Individual Benefit Descriptions

Eyewear - Pediatric **NYS & Federal Essential Health Benefit**	[redacted]		
DENTAL BENEFITS			
Adult Dental			
Pediatric Dental - Emergency Care **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Preventive **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Routine **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Endodontic **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Prosthodontics **NYS & Federal Essential Health Benefit**			
Pediatric Dental - Orthodontics **NYS & Federal Essential Health Benefit**			
PRESCRIPTION DRUGS			
Generic or Tier 1/Tier 2/Tier 3 **NYS & Federal Essential Health Benefit**			
Silver			
Silver 200-250 FPL			
Silver 150-200 FPL			
Silver 100-150 FPL			
Bronze			
WAITING PERIODS			
EXCLUSIONS			

Excellus Health Plan, Inc.
Excellus BlueCross BlueShield

Effective Date: January 1, 2014
Community Rated

2014 Individual Benefit Descriptions

	EXEC-4 Bassett Plan Individual		
Benefit Type	**Bassett Network**	**Non-Preferred**	**Out-of-Network**
PROVIDER NETWORK & SERVICE AREA			
Provider Network Counties - BCBS	Bassett	BCBS 31 counties only	
BCBS Service Area	**Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson**		
Bassett Service Area	**Delaware; Herkimer; Otsego**		
WHO IS COVERED			
Type of Tiers – 4 Tier	Single - Subscriber 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family		
Dependent Coverage **Federal Mandate**	26 to end of month of birthday		
Domestic Partner Coverage	Covered - standard		
COST SHARING EXPENSES			
Contract Year	Calendar Year		
Deductible **· Single/ Family**	[redacted]		
4th Quarter Deductible Carry-Over Y/N	[redacted]		
Copayment	[redacted]		
Coinsurance	[redacted]		
Annual Out-of-Pocket Maximum	[redacted]		
Annual Benefit Maximum **Federal Mandate**	[redacted]		
Lifetime Benefit Maximum **Federal Mandate**	[redacted]		
HOSPITAL INPATIENT SERVICES	[redacted]		
Inpatient Hospital Services **NYS & Federal Essential Health Benefit**	[redacted]		
Mental Health Care **NYS & Federal Essential Health Benefit**	[redacted]		
Residential Treatment	[redacted]		
Substance Use Detoxification **NYS & Federal Essential Health Benefit**	[redacted]		
Substance Use Rehabilitation **NYS & Federal Essential Health Benefit**	[redacted]		
Skilled Nursing Facility **NYS & Federal Essential Health Benefit**	[redacted]		
Physical Rehabilitation **includes habilitative services** **NYS & Federal Essential Health Benefit**	[redacted]		
Maternity Care **NYS & Federal Essential Health Benefit**	[redacted]		
Maternity Care – Routine Newborn Nursery **NYS & Federal Essential Health Benefit**	[redacted]		
Implanted Devices **NYS & Federal Essential Health Benefit**	[redacted]		
End of Life Care **State Mandate** **NYS Essential Health Benefit**	[redacted]		
Observation Stay **NYS & Federal Essential Health Benefit**	[redacted]		
HOME CARE **NYS & Federal Essential Health Benefit**	[redacted]		
HOSPICE CARE **NYS & Federal Essential Health Benefit**	[redacted]		
HOSPITAL OUTPATIENT SERVICES	[redacted]		
Surgical Care including Surgicenters & Freestanding Facilities **NYS & Federal Essential Health Benefit**	[redacted]		
Pre-admission/Pre-Operative Testing **NYS & Federal Essential Health Benefit**	[redacted]		
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**	[redacted]		
Advanced Imaging Services **NYS & Federal Essential Health Benefit**	[redacted]		
Diagnostic & Routine Laboratory and Pathology **NYS & Federal Essential Health Benefit**	[redacted]		
Radiation Therapy **NYS & Federal Essential Health Benefit**	[redacted]		
Chemotherapy **NYS & Federal Essential Health Benefit**	[redacted]		
Infusion Therapy **NYS Essential Health Benefit**	[redacted]		
Dialysis (all forms) **NYS & Federal Essential Health Benefit**	[redacted]		
Mental Health Care **NYS & Federal Essential Health Benefit**	[redacted]		

2014 Individual Benefit Descriptions

Autism Applied Behavior Analysis **State Mandate** **NYS Essential Health Benefit**	[redacted]	
Substance Use Services **NYS & Federal Essential Health Benefit**	[redacted]	
Covered Therapies - Rehabilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**	[redacted]	
Covered Therapies - Habilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**	[redacted]	
Pulmonary Rehabilitation **NYS & Federal Essential Health Benefit**	[redacted]	
Cardiac Rehabilitation **NYS & Federal Essential Health Benefit**	[redacted]	
PHYSICIAN SERVICES	[redacted]	
Inpatient Hospital Surgery **NYS Essential Health Benefit**	[redacted]	
Outpatient Hospital & Ambulatory Surgery **NYS Essential Health Benefit**	[redacted]	
Office Surgery **NYS Essential Health Benefit**	[redacted]	
Anesthesia **Includes IP, OP, OV and maternity** **NYS & Federal Essential Health Benefit**	[redacted]	
Covered Therapies - Rehabilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**	[redacted]	
Covered Therapies - Habilitation **Only Physical, Speech, and Occupational Therapy** **NYS & Federal Essential Health Benefit**	[redacted]	
Additional Surgical Opinion **NYS & Federal Essential Health Benefit**	[redacted]	
Second Medical Opinion for Cancer **NYS & Federal Essential Health Benefit**	[redacted]	rk AE
Maternity Care: Normal, Complications & Termination. **NYS & Federal Essential Health Benefit**	[redacted]	
Prenatal Care **HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]	
PHYSICIAN OFFICE - OTHER SERVICES	[redacted]	
Diagnostic & Routine Laboratory and Pathology **NYS & Federal Essential Health Benefit**	[redacted]	
Diagnostic & Routine X-ray **NYS & Federal Essential Health Benefit**	[redacted]	
Advanced Imaging Services **NYS & Federal Essential Health Benefit**	[redacted]	
Radiation Therapy **NYS & Federal Essential Health Benefit**	[redacted]	
Chemotherapy **NYS & Federal Essential Health Benefit**	[redacted]	
Infusion Therapy **NYS Essential Health Benefit**	[redacted]	
Dialysis (all forms) **NYS & Federal Essential Health Benefit**	[redacted]	
Mental Health Care **NYS & Federal Essential Health Benefit**	[redacted]	
Autism Applied Behavior Analysis **State Mandate** **NYS Essential Health Benefit**	[redacted]	
Substance Use Services **NYS & Federal Essential Health Benefit**	[redacted]	
Office Visits - Diagnostic **NYS & Federal Essential Health Benefit**	[redacted]	
Medications Administered in Office **NYS & Federal Essential Health Benefit**	[redacted]	
Eye Exams - Diagnostic **NYS & Federal Essential Health Benefit**	[redacted]	
Hearing Evaluations Diagnostic **NYS & Federal Essential Health Benefit**	[redacted]	
Chiropractic Care **NYS & Federal Essential Health Benefit**	[redacted]	
Office & Outpatient Consultations **NYS & Federal Essential Health Benefit**	[redacted]	
Allergy Testing **NYS & Federal Essential Health Benefit**	[redacted]	
Allergy Treatment **Includes Serum and Injections** **NYS & Federal Essential Health Benefit**	[redacted]	
Hearing Evaluations Routine **NYS Essential Health Benefit**	[redacted]	
Hearing Aids **NYS & Federal Essential Health Benefit**	[redacted]	

Effective Date: January 1, 2014
Community Rated

2014 Individual Benefit Descriptions

PREVENTIVE SERVICES **Outpatient Facility & Professional Provider**	
Adult Physical Examinations **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]
Adult Immunizations **Federal HCR Preventive Service** **NYS Essential Health Benefit** **Federal Essential Health Benefit**	[redacted]
Well Child Visits and Immunizations **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]
Routine Gynecological Exams **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]
Cervical Cytology Preventive only **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]
Prostate Cancer Screenings **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]
Mammogram Preventive only **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]
Bone Density Testing **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]
Colonoscopy Screening **Federal HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]
Family Planning **HCR Preventive Service** **NYS & Federal Essential Health Benefit**	[redacted]
ADDITIONAL BENEFITS	[redacted]
Treatment of Diabetes Insulin & Supplies **NYS & Federal Essential Health Benefit**	[redacted]
Diabetic Education **NYS & Federal Essential Health Benefit**	[redacted]
Diabetic Equipment **NYS & Federal Essential Health Benefit**	[redacted]
Autism Assistive Communication Devices (ACD) **State Mandate** **NYS Essential Health Benefit**	[redacted]
Autologous Blood Banking **NYS Essential Health Benefit**	[redacted]
Durable Medical Equipment (DME) **NYS & Federal Essential Health Benefit**	[redacted]
External Prosthetics **NYS & Federal Essential Health Benefit**	[redacted]
Orthotics **Foot orthotics included**	[redacted]
Medical Supplies **NYS & Federal Essential Health Benefit**	[redacted]
HEALTH & WELLNESS **Incentive Programs** **NYS & Federal Essential Health Benefit**	[redacted]
EMERGENCY SERVICES **Emergency Condition**	[redacted]
Facility – Emergency Room **NYS & Federal Essential Health Benefit**	[redacted]
Physician's Hospital Emergency Room Visit **NYS & Federal Essential Health Benefit**	[redacted]
Prehospital Emergency Services/Transportation **NYS & Federal Essential Health Benefit**	[redacted]
Freestanding Urgent Care Center **Art 28 Facility** **NYS & Federal Essential Health Benefit**	[redacted]
Physician's Freestanding Urgent Care Center (Art 28 Facility) **NYS & Federal Essential Health Benefit**	[redacted]
Physician Urgent Care Office Visit **NYS & Federal Essential Health Benefit**	[redacted]
VISION BENEFITS	[redacted]
Eye Exams Routine - Adults	[redacted]
Eyewear - Adults	[redacted]
Eye Exams Routine - Pediatric **NYS & Federal Essential Health Benefit**	[redacted]
Eyewear - Pediatric **NYS & Federal Essential Health Benefit**	[redacted]
DENTAL BENEFITS	[redacted]
Adult Dental	[redacted]
Pediatric Dental - Emergency Care **NYS & Federal Essential Health Benefit**	[redacted]
Pediatric Dental - Preventive **NYS & Federal Essential Health Benefit**	[redacted]

2014 Individual Benefit Descriptions

Pediatric Dental - Routine **NYS & Federal Essential Health Benefit**	[redacted]	
Routine - Restorations - Amalgam, Composite & Other Restorativ **Materials**	[redacted]	
Routine - Stainless Steel Crowns	[redacted]	
Pediatric Dental - Endodontic **NYS & Federal Essential Health Benefit**	[redacted]	
Pediatric Dental - Prosthodontics **NYS & Federal Essential Health Benefit**	[redacted]	
Pediatric Dental - Orthodontics **NYS & Federal Essential Health Benefit**	[redacted]	
PRESCRIPTION DRUGS **Closed Formulary**		
Generic or Tier 1/Tier 2/Tier 3 **NYS & Federal Essential Health Benefit**	[redacted]	
Gold	[redacted]	
WAITING PERIODS	[redacted]	
EXCLUSIONS	[redacted]	

2014 Individual Benefit Descriptions

EXER-1
Dependent Coverage through age 29

Benefit Type	In-Network	Out-of-Network
WHO IS COVERED		
Dependents through age 29 State Mandate	Dependent Make Available	

Schedule of Commissions

SECTION A – OUTLINE OF COMMISSIONABLE AND NON-COMMISSIONABLE PRODUCTS

1. **General**

Agent/Broker commissions are limited to fully insured Excellus Health Plan group business purchasing the products listed below. Agent/Broker compensation, however, is based on combined sales under this and any other Schedule A to the Agent/Broker Agreement. This program excludes all: Medicare, Medicaid, Family Health Plus and Child Health Plus products.

If the group falls below the minimum participation requirement, no further commissions will be paid until the minimum participation is restored for that group.

As required by 11 NYCRR 52.42 (e), total commissions payable for HMO products under Section A below are subject to an aggregate maximum of 4% of the approved premium for the contract sold.

2. **Commissionable Medical Products**

A. Large Group
- (1) [HealthyBlue High Deductible Health Plan; ActiveUnivera High Deductible Health Plan]
- (2) [BluePPO HSA Options 1-4; UniveraPPO HSA Options 1-4]
- (3) [SimplyBlue High Deductible Health Plan; valUcare High Deductible Health Plan]
- (4) [HealthyBlue Copay Plan, SimplyBlue Copay Plan; ActiveUnivera Copay Plan, valUcare Copay Plan]
- (5) [HealthyBlue Copay/Deductible Plan, SimplyBlue Copay/Deductible Plan; ActiveUnivera Copay/Deductible Plan, valUcare Copay/Deductible Plan]
- (6) [Excellus BluePPO; UniveraPPO]
- (7) [Blue Point 3; Univera POS Select]
- (8) Blue Preferred PPO
- (9) Excellus BlueEPO
- (10) Blue Point 2]
- (11) [Classic Blue Traditional, Classic Blue Comprehensive, Classic Blue Secure; Classic Univera Traditional, Classic Univera Comprehensive]
- (12) [Blue Choice/HMO Blue $25 and $30]

B. Small Group
- (1) Off- SHOP
  - i. [SimplyBlue+ PPO, valUcare+ PPO]
  - ii. Healthy New York
- (2) SHOP
  - i. [SimplyBlue+ PPO, valUcare+ PPO]

C. Individual
- (1) Off Exchange
  - i. [ExchangeBlueEPO, ExchangeUniveraEPO]
  - ii. [ExchangeBassettEPO]
- (2) [redacted]

3. **Commissionable Dental Products**

A. [Dental Blue Options; Univera Dental Select]
B. [Dental Blue Classic; Univera Dental Traditions]
[C. Smile Saver (Growth only)
D. Dental Blue PPO (Growth only)
E. Dental Options I or II (Growth only)
F. Dental Schedule A, B or C (Growth only)
G. Prime Blue Dental (Growth only)]

SECTION B – MEDICAL BUSINESS

1. **New Medical Business** is commission eligible for employer groups that have not offered Excellus Health Plan products for six months prior to the effective date of coverage.

2. **Existing Medical Business** commissions will be subject to a $150,000 annual maximum per group, with the exception of exclusive business with effective dates on or after January 1, 2014.

3. **Commission Schedules**

   A. Small Group (includes HMO business): 4% of Paid Premium

   B. Large Group (excludes HMO business): % of Paid Premium as follows:

Cumulative YTD Paid Premium	Percent of Paid Premium
First $500,000	4.5%
$500,001 - $1,000,000	4.0%
$1,000,001 - $1,500,000	3.5%
$1,500,001 - $2,000,000	2.5%
$2,000,001-$5,000,000	1.5%
$5,000,001+	1.0%

   C. Individual Market: 2% of paid premium payable as a Per Contract Per Month (PCPM) equivalent.

4. **Medical Business Override Program**

   A. New Medical Business Override

   The New Medical Business Override will be calculated on a quarterly basis beginning 01/01/2014 and paid based on Agent/Broker's year-to-date achievement of new medical contract and new medical group minimum targets according to the schedule below.

   Qualifying new medical contracts must originate from prospect medical clients only. Growth on existing clients is not eligible for New Medical Business Override commissions. Payments will be made on Large Group (non HMO) business only. RMSCO business will be included in the qualifying calculation.

New Medical Contracts	New Medical Group Minimum	Payment
100-249	Two	$15,000
250-499	Two	$30,000
500-999	Three	$50,000
1,000-1,499	Four	$100,000
1,500 or more	Five	$150,000

B. Medical Business Retention Override

The Medical Business Retention Override will be calculated on a calendar year basis and paid based on Agent/Broker's achievement of net medical book of business retention targets according to the schedule below.

Book of business retention measurement will reflect the Agent/Broker's ending medical contract count compared to the starting medical contract count for the period. New medical business acquired during the period will be included in the retention calculation. Payments will be made on Large Group (non HMO) business only. RMSCO business will be included in the qualifying calculation.

% of Medical Contracts Retained	Payment	Maximum Payment
95.0%	0.50% of in force premium	$50,000 per agency
98.0%	0.75% of in force premium	$75,000 per agency

SECTION C – DENTAL BUSINESS

1. **New Dental Business** is commission eligible for employer groups that have not offered Excellus Health Plan dental products for six months prior to the effective date of coverage.

The New Dental Business commission scale will be applied to group business in [Dental Blue Options or Dental Blue Classic; Univera Dental Select or Univera Dental Traditions] plans for all Broker of Record Letters in effect on or after 01/01/2014.

Annual Premium Paid by Group	Commission Percentage
Up to $20,000	12%
$20,001-$30,000	10%
$30,001-$40,000	8%
$40,001-$50,000	6%
$50,001-$100,000	5%
Greater than $100,000	2%

2. **Growth on Existing Dental Business** will qualify for commission eligibility when the Agent/Broker increases dental enrollment within an existing employer by a minimum of one contract.

Annual Premium Paid by Group	Commission Percentage
Up to $20,000	12%
$20,001-$30,000	10%
$30,001-$40,000	8%
$40,001-$50,000	6%
$50,001-$100,000	5%
Greater than $100,000	2%

3. **New Dental Business Override** will be calculated quarterly beginning 01/01/2014 and paid based on Agent/Broker's year-to-date achievement of new dental contract and group minimum targets.

   Qualifying new dental contracts must originate from prospect dental clients only. Growth on existing clients is not eligible for New Business Override commission payment. RMSCO business will be included in the qualifying calculation.

New Dental Contracts	New Dental Group Minimum	Payment
100-199	Two	$2,000
200-299	Three	$5,000
300-399	Four	$10,000
400-499	Five	$15,000
500 or more	Six	$30,000

4. **Dental Business Retention Override** will be calculated on a calendar year basis and paid based on Agent/Broker's achievement of net dental book of business retention targets.

   Book of Business retention measurement will reflect the Agent/Broker's ending dental contract count compared to the starting dental contract count. New dental business acquired during the period will be included in the retention calculation. RMSCO business will be included in the qualifying calculation.

% of Dental Contracts Retained	Payment	Maximum Payment
95.0%	3% of in force premium	$20,000 per agency
98.0%	5% of in force premium	$40,000 per agency

Underwriting Guidelines

Excellus

Medical Commercial Underwriting Guidelines

Applied on a Group Level

Policies Effective: January 1, 2013

Last Revised: November 13, 2012

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Introduction

Commercial health insurance coverage is available to employer, trust and association groups, subscribers and dependents that meet the qualifications specified in 4235 (c) (1) of the New York State Insurance Law and the Underwriting Guidelines of Excellus Health Plan, Inc. d/b/a Excellus BlueCross BlueShield ("Health Plan"). Outlined below are the basic criteria that the Health Plan will follow to qualify employer, trust and association groups, employees and dependents for commercial coverage.

Disclaimer

The Health Plan reserves the right to make exceptions to these guidelines for circumstances where the group/subscriber/dependent does meet all of the criteria in these guidelines and when the exception will not violate any laws/regulations or harm the community pool.

These guidelines are effective January 1, 2013, and replace all previous group commercial guidelines in use.

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I. Group Eligibility

A. Eligible Groups:

A group, or if the group is a trust or association, a member firm participating in the group, is eligible for commercial group coverage if it meets the following criteria:

Employer group/trust:

The group/trust:

1. Is headquartered in the Health Plan's service area. In the event that the Health Plan is insuring only the local employees of multi-location group, the group must have an office in the Health Plan's service area.
2. Is engaged in a legal business or is a government entity with the legal authority to contract.
3. Regularly employs persons on an active basis for salaries or wages throughout the year.
4. Maintains a non-seasonal business in that the group employs at least one employee for 50 percent of the working days in the previous year.
5. Maintains an employer-employee relationship with its subscribers.
6. Files state and federal income taxes as an ongoing commercial enterprise, nonprofit entity, is validly exempted from filing taxes or is a government entity.
7. Meets and maintains applicable participation and contribution requirements as required by the Health Plan's Underwriting Guidelines.

Association groups:

The association:

1. Must meet criteria No. 1 above for employer groups/trusts, as well as other criteria specified in 4235(c)1 related specifically to associations.
2. Member firms must comply with the same underwriting guidelines as groups/trusts enrolled by the Health Plans on a direct basis.

B. Ineligible Groups:

The following groups are ineligible for commercial group coverage:

1. Groups previously terminated for fraud.
2. Groups in bankruptcy proceedings.
3. Groups terminated for nonpayment of premium by any insurance carrier are ineligible as follows:
   a. Small groups (see section "C" below) for 12 months following the termination for nonpayment.
   b. Large groups (see section "C" below) for 24 months following the termination for nonpayment.

C. Group Size:

The definition of sole proprietors is per 4317(f) (3) of the insurance laws of the state of New York. The definition of small groups, including association groups, is in accordance with Regulation 145.

To determine a group's classification as "small" or "large," the Health Plan calculates eligible employees based on the following general guidelines:

1. Groups with common ownership/control count as being part of one group.
2. Groups with membership inside and outside the Health Plan service area will be counted together, even if membership within the service area is minimal.

D. <u>Group Effective Date:</u>

New groups must provide all required enrollment information to the Health Plan 30 days in advance of the effective date. Groups making changes to existing coverage must provide all required enrollment information 15 days in advance of the effective date in order to be effective the 1st of the following month. New small groups must include payment of the first month's premium, along with all other enrollment materials.

E. <u>Group Renewal Date:</u>

Groups renew annually as follows:

1. Community-rated groups renew on January 1, unless the product has rolling rates or a level premium.
2. A group with rolling rates renews on the 1st of the month of the anniversary of its effective date.
3. Level premium or experience-rated groups renew throughout the year, based upon a date the group specifies at the time the rate is quoted.

F. <u>Guaranteed Renewal:</u>

A covered small group or, if the group is a trust or association, a member firm will be renewed unless terminated due to any of the following occurrences:

1. Nonpayment of premium.
2. Fraud or misrepresentation of material facts.
3. Violation of the Health Plan's contribution or participation requirements.
4. Violation of the Health Plan's service area requirements.
5. Lapsed membership or membership is downgraded from "full" to "associate" in the trust or association (including a Chamber of Commerce) through which the coverage is offered.
6. Inability to meet the definition of a permissible group under 4235(c) (1).
7. The Health Plan discontinues participation in the market or discontinues the class of coverage.

G. <u>Open Enrollment Period:</u>

The Health Plan's standard policy is one open enrollment (reopening) period per year, at the time of the group's renewal. The open enrollment period is the time when eligible group members who have previously declined coverage through the group may enroll. Subscribers may select from among the various offerings available through the group during the open enrollment period.

H. Special Open Enrollment Periods:

A group may request a special open enrollment period when a significant change in business conditions occurs, such as a purchase of a new division or the group expands coverage to a new class of employees.

II. Subscriber/Dependent Eligibility

A. Eligible Subscriber:

An eligible subscriber must be a citizen of the United States or must be in the United States validly working on at least a semi-permanent basis (e.g., "H" visa). If the product covering the subscriber has a limited network or requires election of a primary care physician, the subscriber must live, work or reside in the appropriate Health Plan service area.

Additionally, under various group situations, an eligible subscriber must meet the following criteria.

For coverage through an employer group (including member firms within a trust or association), an eligible subscriber must be:

1. A permanent, full or part-time employee working at least 20 hours per week.
2. An officer or director if engaged in the operation of the business at least 20 hours per week and receiving compensation. An owner of a business is eligible regardless of whether he or she actively works at the business, unless the owner is determined to be a silent partner (i.e., exerting no influence on the management or operation of the business).
3. An elected or appointed official if the employer group is a public entity (e.g., city, school district).
4. If a retiree, covered by the Health Plan immediately prior to retirement and with continuous coverage through the Health Plan.
5. An employee disabled or on FMLA [spell out].
6. A former employee on COBRA/New York state extension of benefits, until the maximum period ends.
7. A reservist.
8. A "1099 employee" who is considered an employee per Department of Labor regulations (e.g., realtors, contractors).

Note: Large groups may insure employees who work 17.5 hours or more.

For coverage through a professional society (e.g., medical, bar, realtors), an eligible subscriber must:

1. Qualify for full membership in the professional society under the organization's bylaws.
2. Be a licensed professional.

B. Employer Probationary Periods:

Employers may select probationary periods from zero (0) to one (1) year in monthly increments.

C. Eligible Dependent:

The eligible dependents are dictated by the subscriber contract/certificate. In general, the eligible dependents are as follows:

1. Spouses
   a. Spouse, unless the marriage is dissolved through divorce or annulment. A same-sex marriage will be recognized when the marriage is performed in a state where full legal status is conferred.

2. Dependent Children
   a. Children of a subscriber are covered until age 26 regardless of financial dependence, residency, student status, employment, marital status, or eligibility for other coverage (unless, until January 1, 2014, the subscriber is covered under a grandfathered group health plan, in which case the dependent must not be eligible for coverage through his/her own employer).

   b. In addition to the coverage listed in subparagraph a. above, coverage for the children of a subscriber is available, if elected by the subscriber or eligible young adult, for unmarried young adults younger than 30 years of age who are not insured or eligible for insurance through their own employer, who live, work or reside in New York state or the Health Plan's service area and who are not covered under Medicare.

   c. In addition to the coverage listed in subparagraph a. above, coverage may be available through a "make available" rider, if elected by a group, for the children of a subscriber who are unmarried, younger than 30 years of age, who are not insured or eligible for insurance through their own employer, who live, work or reside in New York state or the Health Plan's service area, and who are not covered by Medicare.

   d. For purposes of subparagraphs b. and c. above, the term "children" includes natural children, stepchildren, legally adopted children and children for whom a court of law has made the subscriber or spouse legally responsible to support.

D. Subscriber/Dependent Initial Enrollment and Retroactivity

The Health Plan will enroll a subscriber and/or dependent for the requested date, provided that:

1. The application is received within the retroactive period specified in the subscriber contract/certificate from the date of the qualifying event.
2. If the retroactive period is unspecified, within 30 days.

If not enrolled when initially eligible, the subscriber/dependent must wait until the next open enrollment period, unless the subscriber/dependent qualifies for a special enrollment period (see following Section E).

E. Special Enrollment Periods:

The Health Plan recognizes the special enrollment rights available to covered persons under federal and state law and/or regulation. These special enrollment rights allow an employee, spouse or dependent who did not enroll in the group plan when originally eligible due to

coverage under the spouse's employer group plan to enroll for coverage at a time other than the group's open enrollment period, if the other coverage is lost for one or more of the following reasons:

1. Termination of the spouse's employment.
2. Termination of the spouse's other plan or benefit contract.
3. Death of the spouse.
4. Legal separation, divorce or annulment.
5. Reduction in the number of hours worked by the spouse.
6. Employer ceased its contribution toward the premium for the spouse's plan or benefit contract.

If the employee, spouse or dependent applies within 30 days of the loss of coverage or within such longer period specified in the subscriber contract or certificate, he or she may enroll effective the date of the loss of coverage.

F. Pre-existing Conditions:

The definition of waiting periods for pre-existing conditions is in the subscriber contract/certificate. Pre-existing conditions applies for the period specified in the subscriber contract/certificate, for services in connection with any disease, illness, ailment or other condition where medical advice, diagnosis, care or treatment was actually recommended by or received from a licensed health care provider within six months before the coverage began. Pregnancy or conditions in newborns or adopted children enrolled within 31 days of birth are not subject to pre-existing conditions.

The Health Plan will count all sources of creditable coverage, as defined by law, toward the subscriber's or dependent's waiting period(s). Employer probationary periods, if any, are included as credit toward the waiting period.

Pre-existing waiting periods, for dependents and subscribers 19 years of age and older, apply to the Health Plan's commercial group coverage as follows:

1. Groups with 50 or fewer eligible employees must have pre-existing waiting period provisions.
2. Groups with 51 to 299 eligible employees may select not to have pre-existing waiting period provisions.
3. Groups with 300 or more eligible employees must not have pre-existing waiting period provisions.

Members younger than 19 may not be subject to pre-existing condition limitations.

III. Product Offering Requirements

A. Participation Percents:

HMO products are not subject to participation requirements, but enrollment in the Health Plan's HMO products may contribute to the total participation percentages.

The group size and participation requirements are based on net-eligible employees (after valid waivers). To obtain or maintain group coverage, 75 percent of the net-eligible employees must be enrolled in our Health Plan and meet applicable state law participation requirements.

B. Maximum Number of Products or Options:

Groups meeting standard participation requirements may select the following number of products/options:

Enrolled Employees	Number of Products/Options
1 – 5	1
6 – 20	2
21 – 50	3
51 - 499	4
500+	Negotiated among Sales, Rating and Underwriting

Groups with multiple product/option selections may choose the same or different types of products, but may not cause adverse selection by violating the Health Plan's multiple product offering guidelines. See Section C below.

C. Multiple Offerings:

To reduce the potential for adverse selection, the following rules govern which products are available in multiple product offering situations:

1. When offered next to a competitor, the benefit level of the Health Plan's products must be less than the competitor's benefit offering.
2. When multi-option offerings are offered next to a competitor's plan, our lowest option has to be the lowest option offered, and we must have enrollment in this option.
3. All offerings must either include or exclude drugs. High/low offerings may have different drug benefits, but the high base/high drug benefit and the low base/low drug benefit must be paired together.
4. The eligibility criteria for subscribers and dependents must be the same for all products (e.g., domestic partner, student age).
5. The underlying benefits must be essentially the same, except for benefits such as vision, which have a low risk of adverse selection.
6. Rating tiers must be identical.
7. Renewal/open enrollment periods must be the same.
8. The rate differential among Health Plan product offerings must be at least 5 percent and no more than 30 percent. If a health savings account product is offered, special consideration may be given.
9. If an HSA is offered in conjunction with another product in groups of one to five, two products/offerings, rather than one product/offering may be allowed.

D. Employer Contribution:

The employer must contribute a minimum of 50 percent of the single premium for each product offering.

E. Group-Initiated Changes in Coverage:

If a group wishes to change its coverage, the following rules are generally in effect:

1. Riders may be added or eliminated only at the renewal.
2. Groups that eliminate riders may not add the rider to coverage for a period of two years. This includes prescription drug and eligibility riders.
3. For experience-rated groups, benefit changes should occur at the renewal date. One off-cycle change may occur per calendar year, subject to prior approval.

For community-rated groups,

1. Upgrades may occur once per year at the time of renewal.
2. Downgrades off-renewal will need prior approval and must have a rate differential of at least 5 percent. No downgrades will be allowed three months prior to or after the group's renewal date. Other conditions apply.

F. Rating:

Sole proprietors and groups with 2 to 50 eligible employees are community-rated. Sole proprietors receive a surcharged rate. Rates are based upon the group's location and product selection, in accordance with rates filed with the New York State Department of Financial Services.

Groups with 51 or more eligible employees will be experience-rated for Article 43 products.

G. Rate Changes:

For community-rated plans, the Health Plan must provide notice to the group policyholder or contract holder, as well as certificate holders, on or before the date the Health Plan files its initial rate change filing with the New York State Insurance Department. The Health Plan may provide the group policyholder or contract holder with a sufficient supply of rate change notices for distribution to certificate holders. The rate contained in the notice to group policyholders or contract holders and certificate holders must be no more than 5 percent from the actual rate. Upon receipt of approval of its rate change application, the Health Plan must provide the group policyholder or contract holder, as well as certificate holders, with 60 days prior written notice of the approved rate change before it may be implemented.

Rates for experience-rated groups are prepared in accordance with a formula filed with the New York State Department of Financial Services. The experience-rated groups receive notice of the rate change at least 60 days in advance of the effective date of the rate change.

IV. Other Requirements

Eligibility Verification:

New group and subscriber/dependent eligibility and guideline compliance will be verified using information from tax forms, other filings with government agencies and appropriate company records as determined by the Underwriting Department. Recertification of a group will occur annually through a direct request for information from the Health Plan. The annual cycle will repeat as long as the group purchases health insurance coverage from the Health Plan.

Medical Commercial Underwriting Guidelines

Applied on a Group Level

Policies Effective: January 1, 2013

Last Revised: November 13, 2012

Introduction

Commercial health insurance coverage is available to employer, trust and association groups, subscribers and dependents that meet the qualifications specified in 4235 (c) (1) of the New York State Insurance Law and the Underwriting Guidelines of Excellus Health Plan, Inc. d/b/a Univera Healthcare ("Health Plan"). Outlined below are the basic criteria that the Health Plan will follow to qualify employer, trust and association groups, employees and dependents for commercial coverage.

Disclaimer

The Health Plan reserves the right to make exceptions to these guidelines for circumstances where the group/subscriber/dependent does meet all of the criteria in these guidelines and when the exception will not violate any laws/regulations or harm the community pool.

These guidelines are effective January 1, 2013, and replace all previous group commercial guidelines in use.

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I. Group Eligibility

A. Eligible Groups:

A group, or if the group is a trust or association, a member firm participating in the group is eligible for commercial group coverage if it meets the following criteria:

Employer group/trust:

The group/trust:

1. Is headquartered in the Health Plan's service area. In the event that the Health Plan is insuring only the local employees of multi-location group, the group must have an office in the Health Plan's service area.
2. Is engaged in a legal business or is a government entity with the legal authority to contract.
3. Regularly employs persons on an active basis for salaries or wages throughout the year.
4. Maintains a non-seasonal business in that the group employs at least one employee for 50 percent of the working days in the previous year.
5. Maintains an employer-employee relationship with its subscribers.
6. Files state and federal income taxes as an ongoing commercial enterprise, nonprofit entity, is validly exempted from filing taxes or is a government entity.
7. Meets and maintains applicable participation and contribution requirements as required by the Health Plan's Underwriting Guidelines.

Association groups:

The association:

1. Must meet criteria No. 1 above for employer groups/trusts, as well as other criteria specified in 4235(c)1 related specifically to associations.
2. Member firms must comply with the same underwriting guidelines as groups/trusts enrolled by the Health Plans on a direct basis.

B. Ineligible Groups:

The following groups are ineligible for commercial group coverage:

1. Groups previously terminated for fraud.
2. Groups in bankruptcy proceedings.
3. Groups terminated for nonpayment of premium by any insurance carrier are ineligible as follows:
   a. Small groups (see section "C" below) for 12 months following the termination for nonpayment.
   b. Large groups (see section "C" below) for 24 months following the termination for nonpayment.

C. Group Size:

The definition of sole proprietors is per 4317(f) (3) of the insurance laws of New York state. The definition of small groups, including association groups, is in accordance with Regulation 145.

To determine a group's classification as "small" or "large," the Health Plan calculates eligible employees based on the following general guidelines:

1. Groups with common ownership/control count as being part of one group.

2. Groups with membership inside and outside the Health Plan service area will be counted together, even if membership within the service area is minimal.

D. Group Effective Date:

New groups must provide all required enrollment information to the Health Plan 30 days in advance of the effective date. Groups making changes to existing coverage must provide all required enrollment information 15 days in advance of the effective date in order to be effective the 1st of the following month. New small groups must include payment of the first month's premium, along with all other enrollment materials.

E. Group Renewal Date:

Groups renew annually as follows:

1. Community-rated groups renew on January 1, unless the product has rolling rates or a level premium.
2. A group with rolling rates renews on the 1st of the month of the anniversary of its effective date.
3. Level premium or experience-rated groups renew throughout the year, based upon a date the group specifies at the time the rate is quoted.

F. Guaranteed Renewal:

A covered small group or, if the group is a trust or association, a member firm will be renewed unless terminated due to any of the following occurrences:

1. Nonpayment of premium.
2. Fraud or misrepresentation of material facts.
3. Violation of the Health Plan's contribution or participation requirements.
4. Violation of the Health Plan's service area requirements.
5. Lapsed membership or membership is downgraded from "full" to "associate" in the trust or association (including a Chamber of Commerce) through which the coverage is offered.
6. Inability to meet the definition of a permissible group under 4235(c) (1).
7. The Health Plan discontinues participation in the market or discontinues the class of coverage.

G. Open Enrollment Period:

The Health Plan's standard policy is one open enrollment (reopening) period per year, at the time of the group's renewal. The open enrollment period is the time when eligible group members who have previously declined coverage through the group may enroll. Subscribers may select from among the various offerings available through the group during the open enrollment period.

H. Special Open Enrollment Periods:

A group may request a special open enrollment period when a significant change in business conditions occurs, such as a purchase of a new division or the group expands coverage to a new class of employees.

II. Subscriber/Dependent Eligibility

A. Eligible Subscriber:

An eligible subscriber must be a citizen of the United States or must be in the United States validly working on at least a semi-permanent basis (e.g., “H” visa). If the product covering the subscriber has a limited network or requires election of a primary care physician, the subscriber must live, work or reside in the appropriate Health Plan service area.

Additionally, under various group situations, an eligible subscriber must meet the following criteria.

For coverage through an employer group (including member firms within a trust or association), an eligible subscriber must be:

1. A permanent, full or part-time employee working at least 20 hours per week.
2. An officer or director if engaged in the operation of the business at least 20 hours per week and receiving compensation. An owner of a business is eligible regardless of whether he or she actively works at the business, unless the owner is determined to be a silent partner (i.e., exerting no influence on the management or operation of the business).
3. An elected or appointed official if the employer group is a public entity (e.g., city, school district).
4. If a retiree, covered by the Health Plan immediately prior to retirement and with continuous coverage through the Health Plan.
5. An employee disabled or on FMLA [spell out].
6. A former employee on COBRA/New York state extension of benefits, until the maximum period ends.
7. A reservist.
8. A “1099 employee” who is considered an employee per Department of Labor regulations (e.g., realtors, contractors).

Note: Large groups may insure employees who work 17.5 hours or more.

For coverage through a professional society (e.g., medical, bar, realtors), an eligible subscriber must:

1. Qualify for full membership in the professional society under the organization’s bylaws.
2. Be a licensed professional.

B. Employer Probationary Periods:

Employers may select probationary periods from zero (0) to one (1) year in monthly increments.

C. Eligible Dependent:

The eligible dependents are dictated by the subscriber contract/certificate. In general, the eligible dependents are as follows:

1. Spouses
   a. Spouse, unless the marriage is dissolved through divorce or annulment. A same-sex marriage will be recognized when the marriage is performed in a state where full legal status is conferred.

2. Dependent Children

a. Children of a subscriber are covered until age 26 regardless of financial dependence, residency, student status, employment, marital status, or eligibility for other coverage (unless, until January 1, 2014, the subscriber is covered under a grandfathered group health plan, in which case the dependent must not be eligible for coverage through his/her own employer).

b. In addition to the coverage listed in subparagraph a. above, coverage for the children of a subscriber is available, if elected by the subscriber or eligible young adult, for unmarried young adults younger than 30 years of age who are not insured or eligible for insurance through their own employer, who live, work or reside in New York state or the Health Plan's service area and who are not covered under Medicare.

c. In addition to the coverage listed in subparagraph a. above, coverage may be available through a "make available" rider, if elected by a group, for the children of a subscriber who are unmarried, younger than 30 years of age, who are not insured or eligible for insurance through their own employer, who live, work or reside in New York state or the Health Plan's service area, and who are not covered by Medicare.

d. For purposes of subparagraphs b. and c. above, the term "children" includes natural children, stepchildren, legally adopted children and children for whom a court of law has made the subscriber or spouse legally responsible to support.

D. Subscriber/Dependent Initial Enrollment and Retroactivity

The Health Plan will enroll a subscriber and/or dependent for the requested date, provided that:

1. The application is received within the retroactive period specified in the subscriber contract/certificate from the date of the qualifying event.
2. If the retroactive period is unspecified, within 30 days.

If not enrolled when initially eligible, the subscriber/dependent must wait until the next open enrollment period, unless the subscriber/dependent qualifies for a special enrollment period (see following Section E).

E. Special Enrollment Periods:

The Health Plan recognizes the special enrollment rights available to covered persons under federal and state law and/or regulation. These special enrollment rights allow an employee, spouse or dependent who did not enroll in the group plan when originally eligible due to coverage under the spouse's employer group plan to enroll for coverage at a time other than the group's open enrollment period, if the other coverage is lost for one or more of the following reasons:

1. Termination of the spouse's employment.
2. Termination of the spouse's other plan or benefit contract.
3. Death of the spouse.
4. Legal separation, divorce or annulment.
5. Reduction in the number of hours worked by the spouse.
6. Employer ceased its contribution toward the premium for the spouse's plan or benefit contract.

If the employee, spouse or dependent applies within 30 days of the loss of coverage or within such longer period specified in the subscriber contract or certificate, he or she may enroll effective the date of the loss of coverage.

F. Pre-existing Conditions:

The definition of waiting periods for pre-existing conditions is in the subscriber contract/certificate. Pre-existing conditions applies for the period specified in the subscriber contract/certificate, for services in connection with any disease, illness, ailment or other condition where medical advice, diagnosis, care or treatment was actually recommended by or received from a licensed health care provider within six months before the coverage began. Pregnancy or conditions in newborns or adopted children enrolled within 31 days of birth are not subject to pre-existing conditions.

The Health Plan will count all sources of creditable coverage, as defined by law, toward the subscriber's or dependent's waiting period(s). Employer probationary periods, if any, are included as credit toward the waiting period.

Pre-existing waiting periods, for dependents and subscribers 19 years of age and older, apply to the Health Plan's commercial group coverage as follows:

1. Groups with 50 or fewer eligible employees must have pre-existing waiting period provisions.
2. Groups with 51 to 299 eligible employees may select not to have pre-existing waiting period provisions.
3. Groups with 300 or more eligible employees must not have pre-existing waiting period provisions.

Members younger than 19 may not be subject to pre-existing condition limitations.

III. Product Offering Requirements

A. Participation Percents:

HMO products are not subject to participation requirements, but enrollment in the Health Plan's HMO products may contribute to the total participation percentages.

The group size and participation requirements are based on net-eligible employees (after valid waivers). To obtain or maintain group coverage, 75 percent of the net-eligible employees must be enrolled in our Health Plan and meet applicable state law participation requirements.

B. Maximum Number of Products or Options:

Groups meeting standard participation requirements may select the following number of products/options:

Enrolled Employees	Number of Products/Options
1 – 5	1
6 – 20	2
21 – 50	3
51 - 499	4
500+	Negotiated among Sales, Rating and Underwriting

Groups with multiple product/option selections may choose the same or different types of products, but may not cause adverse selection by violating the Health Plan's multiple product offering guidelines. See Section C below.

C. Multiple Offerings:

To reduce the potential for adverse selection, the following rules govern which products are available in multiple product offering situations:

1. When offered next to a competitor, the benefit level of the Health Plan's products must be less than the competitor's benefit offering.
2. When multi-option offerings are offered next to a competitor's plan, our lowest option has to be the lowest option offered, and we must have enrollment in this option.
3. All offerings must either include or exclude drugs. High/low offerings may have different drug benefits, but the high base/high drug benefit and the low base/low drug benefit must be paired together.
4. The eligibility criteria for subscribers and dependents must be the same for all products (e.g., domestic partner, student age).
5. The underlying benefits must be essentially the same, except for benefits such as vision, which have a low risk of adverse selection.
6. Rating tiers must be identical.
7. Renewal/open enrollment periods must be the same.
8. The rate differential among Health Plan product offerings must be at least 5 percent and no more than 30 percent. If a health savings account product is offered, special consideration may be given.
9. If an HSA is offered in conjunction with another product in groups of one to five, two products/offerings, rather than one product/offering may be allowed.

D. Employer Contribution:

The employer must contribute a minimum of 50 percent of the single premium for each product offering.

E. Group-Initiated Changes in Coverage:

If a group wishes to change its coverage, the following rules are generally in effect:

1. Riders may be added or eliminated only at the renewal.
2. Groups that eliminate riders may not add the rider to coverage for a period of two years. This includes prescription drug and eligibility riders.
3. For experience-rated groups, benefit changes should occur at the renewal date. One off-cycle change may occur per calendar year, subject to prior approval.

For community-rated groups,

1. Upgrades may occur once per year at the time of renewal.
2. Downgrades off-renewal will need prior approval and must have a rate differential of at least 5 percent. No downgrades will be allowed three months prior to or after the group's renewal date. Other conditions apply.

F. Rating:

Sole proprietors and groups with 2 to 50 eligible employees are community-rated. Sole proprietors receive a surcharged rate. Rates are based upon the group's location and product selection, in accordance with rates filed with the New York State Department of Financial Services.

Groups with 51 or more eligible employees will be experience-rated for Article 43 products.

G. Rate Changes:

For community-rated plans, the Health Plan must provide notice to the group policyholder or contract holder, as well as certificate holders, on or before the date the Health Plan files its initial rate change filing with the New York State Insurance Department. The Health Plan may provide the group policyholder or contract holder with a sufficient supply of rate change notices for distribution to certificate holders. The rate contained in the notice to group policyholders or contract holders and certificate holders must be no more than 5 percent from the actual rate. Upon receipt of approval of its rate change application, the Health Plan must provide the group policyholder or contract holder, as well as certificate holders, with 60 days prior written notice of the approved rate change before it may be implemented.

Rates for experience-rated groups are prepared in accordance with a formula filed with the New York State Department of Financial Services. The experience-rated groups receive notice of the rate change at least 60 days in advance of the effective date of the rate change.

IV. Other Requirements

Eligibility Verification:

New group and subscriber/dependent eligibility and guideline compliance will be verified using information from tax forms, other filings with government agencies and appropriate company records as determined by the Underwriting Department. Recertification of a group will occur annually through a direct request for information from the Health Plan. The annual cycle will repeat as long as the group purchases health insurance coverage from the Health Plan.

Expected Loss Ratio

Excellus Health Plan, Inc.
Excellus BCBS
Univera Healthcare

Expected Loss Ratio

Individual Pool 88.1%

Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	The product checklists are attached.
Attachment(s):	EXEC-1 Checklist.pdf EXEC-2 Checklist.pdf EXEC-3 Checklist.pdf EXEC-4 Checklist.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	The Flesch Score Certifications are attached.
Attachment(s):	EXEC-1, et al. FleschCert Waiver Request.pdf EXER-1 FleschCert.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variability
Comments:	The Memoranda of Variable Material as revised in response to your May 29 Objection Letter are attached.
Attachment(s):	EXEC-1 MOVM 060113.pdf EXEC-2 MOVM 060113.pdf EXEC-3 MOVM 060113.pdf EXEC-4 MOVM 060113.pdf EXER-1 MOVM 053113.pdf EXER-2 MOVM 053013.pdf Schedules of Benefits MOVM (Individual) 060113.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Black-lined Copy of Model Language

State: New York **Filing Company:** Excellus Health Plan, Inc.
TOI/Sub-TOI: H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense
Product Name: ExchangeBlue EPO/Exchange Univera EPO
Project Name/Number: Individual On/Off Exchange/

Bypass Reason:	Not applicable. The Plan did not include any new language or modify any language from the Model Language, unless specifically permitted by the drafting instructions. Accordingly, we believe black-lined copies are not necessary.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	Attached is the Actuarial Memorandum for the Individual plans, revised to reflect the change in the Catastrophic plan benefit communicated by the Department on 5/6/2013.
Attachment(s):	Actuarial Memorandum - Individual 5.8.2013.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	Attached is the Actuarial Memorandum for the Individual plans, revised to reflect the change in the Catastrophic plan benefit communicated by the Department on 5/6/2013. This is the same as the document above.
Attachment(s):	Actuarial Memorandum - Individual 5.8.2013.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Individual Medical Rate Instructions/Checklist
Comments:	Checklist received, thank you.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations
Comments:	Attached are the AV Calculations for the Individual plans, revised to reflect the change in the Catastrophic plan benefit communicated by the Department on 5/6/2013.
Attachment(s):	AV Calculations Individual 05.08.2013.pdf
Item Status:	

State: *New York* **Filing Company:** *Excellus Health Plan, Inc.*
TOI/Sub-TOI: *H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name: *ExchangeBlue EPO/Exchange Univera EPO*
Project Name/Number: *Individual On/Off Exchange/*

Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	Attached are the Unified Rate Review materials of the Individual on and off Exchange plans, revised to reflect the change in the Catastrophic plan benefit communicated by the Department on 5/6/2013.
Attachment(s):	Unified_Rate_Review_Template IND On & Off Exchange FINAL v3 05.08.2013.pdf Unified_Rate_Review_Template IND On & Off Exchange FINAL v3 05.08.2013.xlsm
Item Status:	
Status Date:	

State: New York **Filing Company:** Excellus Health Plan, Inc.
TOI/Sub-TOI: H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense
Product Name: ExchangeBlue EPO/Exchange Univera EPO
Project Name/Number: Individual On/Off Exchange/

Attachment Unified_Rate_Review_Template IND On & Off Exchange FINAL v3 05.08.2013.xlsm is not a PDF document and cannot be reproduced here.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Individual Health Benefits Exchange Checklist

As of 4/09/13

Instructions for SERFF Checklist:

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

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

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

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

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

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Individual Health Benefits Exchange Checklist

LINE OF BUSINESS: **Individual Exchange**

TOI	LINE(S) OF INSURANCE	Sub-TOI
HOrg021	Individual Health Organization Health Maintenance (HMO)	HOrg021.005B Individual POS HOrg021.005D Individual HMO
Individual Health	Major Medical	H161.005A Individual PPO H161.005C Individual Other
Individual Health	Hospital Surgical Medical Expense	H15I.001 Health
H06	Health Conversion	H06.000 Conversion

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

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

		No agent or representative of such corporation and no broker, other than an officer or officers designated therin, is authorized to change the contract or waive any of its provisions. *Note: If this contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the insurer a part of the contract, such portion shall be set forth in full.* If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☐ No ☐ (If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF.	No strikeouts Form number in lower left-hand corner of cover page In form intended for use No illustrative material Variable material explained in MOVM Form placed on SERFF Form Schedule
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.	Bypassed in SERFF
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF filing description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form 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)	Filing description in SERFF. Refers to Form Schedule tab for list of forms by form number
Discrimination	§2606 §2607 §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, or marital status.	No discriminatory provisions

APPLICATION FORMS Model Application Used? Yes ☐ No ☐	Model Language		Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	Model not yet available
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	
Prohibited Questions and Provisions	§3216(c)(5)(a) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy void. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	EXEC-1 Cover page
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Cover page
Free Look	§4306 §3216(c)(10)	This contract or policy contains a "free look" provision that is for a period of not less than 10 days and not more than 20 days.	Cover page
Brief Statement	§4306(m)	This contract or policy contains a brief description of the contract on its first page.	Cover page
Table of Contents Model Language Used? Yes ☒ No ☐	§ 3102(c)(1)(G) Model Language	A table of contents is required.	pp. 1, 2
DEFINITIONS Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	*Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.*	Form/Page/Para Reference
Services Performed at	§4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or	

Comprehensive Care Center for Eating Disorders	§4328	contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Services not excluded
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	p. 9, paras 3, 4
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☐ No ☒	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	PCP designation not required
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☐ No ☒	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer.	PCP designation not required
Preauthorization			
Preauthorization Requirements Model Language Used?	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b)	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or	

Yes ☒ No ☐	Model Language	$500.00, whichever is less, is permissible.	p. 9, para 5
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes ☒ No ☐	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	pp. 9, 10, para 7
Contact Information Model Language Used? Yes ☒ No ☐	§3217-a(a)(16) §4324(a)(16) PHL§4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	pp. 10, 11, para 8
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes ☐ No ☒	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	p. 12
Specialty Care Provider as PCP Model Language Used? Yes ☐ No ☒	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	PCP designation not required
Standing Referrals Model Language Used? Yes ☐ No ☒	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	PCP designation not required
Specialty Care Center Model Language Used? Yes ☐ No ☒	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	PCP designation not required
Transitional Care When A Provider Leaves the Network	§4804(e) §3217-d(c) §4306-C(c)	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the	

Model Language Used? Yes ☒ No ☐	PHL §4403(6)(e) Model Language	provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	p. 12
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ☒ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	pp. 12, 13
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes ☒ No ☐	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	p. 14, para 2
Reimbursement of Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	p. 15, para 5
Non-Participating Providers and Non-Authorized Services	§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.	

Model Language Used? Yes ☒ No ☐			Cover page
ELIGIBILITY Model Language Used? Yes ☒ No ☐	Model Language	For each of the following eligibility provisions model language must be used.	Form/Page/Para Reference
Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	p. 16
Spouse	§4235(f)(1)(A) §4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	p. 16, model language used
Dependents	§4235(f)(1)(A)(i) §4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. *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.*	p. 16
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *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.*	p. 16
Newborn Infants	§4235(f)(2) §4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the*	p. 18

		insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.	
Adopted Children and Step-Children	11NYCRR52.17(a)(30), (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	p. 16
Domestic Partners	§4235(f)(1)(A) §4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • 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.	pp. 19, 20
Enrollment Periods	45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	pp. 17, 18
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	*The following benefits must be included in the policy or contract form.* **Standard Products:** Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits.	Form/Page/Para Reference

		All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart. **Non-Standard Products:** Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative	
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☒ No ☐	§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	p. 21, para A
Federally Mandated Preventive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	pp. 21, 22

Cervical Cytology Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(15) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	p. 22, para D
Mammography Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes the following coverage for mammography screening for occult breast cancer: • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	p. 22, para E
Family Planning & Reproductive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §4328 §3216(i)(10) §3216(l)	This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 22, 23, para F
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☒ No ☐	§3216(l) §4328 § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals: • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for	p. 23, para G

		osteoporosis. Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance	
Prostate Cancer Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 23, para H
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(24) § 4303(aa) Model Language	**Emergency Medical and Ambulance Services:** This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person's bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person. An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization. **Non-Emergency Ambulance Services:** This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:	pp. 24, 25

		• From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	
Emergency Services Model Language Used? Yes ☒ No ☐	§4328 §4303(a)(2) §3316(i)(9) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be*	pp. 26, 27

		necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).	
Urgent Care Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l)	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	pp. 27, 28
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Allergy Testing and Treatment Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Ambulatory Surgery Center Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Chemotherapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Chiropractic Care Model Language Used? Yes ☒ No ☐	§3216(i)(21) §4328 §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or sublaxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such	p. 29

		amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	
Dialysis Coverage Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.	pp. 29, 30
Outpatient Habilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the*	§4328 §3216(l) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 30

addition of benefits to EHB categories are only permissible in Non-Standard Products. Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.		*Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per condition; cover visits per year rather than per condition; and may remove the lifetime limit.*	Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Home Health Services Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(6) §4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.	p. 30

		Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.	
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. *Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.*	p. 30
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(13) 4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded for Non-Standard Products. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	pp. 30, 31
Infusion Therapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(i)(15-a)(A) §3216(l) 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.	p. 31
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) 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.	p. 31
Office Visits	45 CFR § 156.100	This policy or contract form provides coverage for office visits for the diagnosis and treatment of	

Model Language Used? Yes ☒ No ☐	§4328 §3216(l) Model Language	injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Outpatient Hospital Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Preadmission Testing Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(7) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Outpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more*	pp. 32, 33 Form is for both standard and non-standard products and benefit is the same for both.

this substitution or addition differs from the Standard benefit in the space provided.		*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.*	
Non-Standard Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(19)(A)(i) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 33
Second Surgical Opinion Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(8) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 33
Mandatory Second Surgical Opinion Model Language Used? Yes ☒ No ☐	4303(b) §4328 Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	p. 33
Second Opinion in Other Cases Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 33
Surgical Services	45 CFR § 156.100 §4328	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	

Model Language Used? Yes ☒ No ☐	§3216(l) 11 NYCRR § 52.6 Model Language	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.	pp. 33, 34
Oral Surgery Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) §4328 §3216(l) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 34
Mastectomy Care Model Language Used? Yes ☒ No ☐	§3216(l) §3216(i)(20) §4328 §4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 43
Post Mastectomy Reconstruction Model Language Used? Yes ☒ No ☐	§3216(i)(20) §4328 §4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	p. 34
Transplants	45 CFR § 156.100 §3215(l)	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,	

Model Language Used? Yes ☒ No ☐	§4328 Model Language	and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 34, 35
Autism Spectrum Disorder Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(25) Model Language 11 NYCRR 440	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. This policy or contract form shall include a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy or contract form shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year. The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.	pp. 36-38

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§3216(i)(15-a) §4328 §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3216(i)(15-a) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. *Note: For **Standard Products**, the medical benefit cost-sharing must apply. For **Non-Standard** Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.* *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.*	pp. 38-39
Durable Medical Equipment and Braces Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 39, 40
Hearing Aids Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. *{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}*	p. 40

		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(o) 45 CFR § 156.100 Model Language	This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits. *Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.*	p. 40
Prosthetics Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	External Prosthetic Devices**:** This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.* Internal Prosthetic Devices**:** This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 40, 41

Hospital Services Model Language Used? Yes ☐ No ☐	11NYCRR52.5 45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 42
Maternity Care Model Language Used? Yes ☒ No ☐	§3216(i)(10) §4328 4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3216(i)(10), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.	pp. 42, 43

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 43
Inpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. *Note: The Standard Exchange Plan must cover 60 days. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the "per condition" and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	p. 43 Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Skilled Nursing Facility	§3216(i)(6)	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility,	

Model Language Used? Yes ☒ No ☐	§4328 §4303(d) 45 CFR § 156.100 Model Language	including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 43
End of Life Care Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	p. 44
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	§4328 §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, individual policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	p. 45
Outpatient Mental Health Care Services Model Language Used? Yes ☐ No ☐	§3216(i)(4) §4328 §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No.	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.	p. 45

	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	Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
Inpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	p. 45
Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to	This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of	p. 46

	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	opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.* *Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the	pp. 47-55

		same number of prescription drugs in each category and class as the benchmark plan. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Enteral Formulas Model Language Used? Yes ☒ No ☐	§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 47
Off-Label Cancer Drug Usage Model Language Used? Yes ☒ No ☐	§3216(i)(12) §4328 §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	pp. 47, 48
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	p. 49, para 2, p. 50, para 5
Prohibition for Tier IV Drugs	§4328 §3216(l) §4303(gg) PHL §4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	No Tier IV Drug benefits
Eye Drops Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not	p. 48

		limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Orally Administered Anticancer Medications Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(12-a)(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.	pp. 51, 52, para 9
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §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.	p. 51, para 8
Contraceptive Drugs and Devices Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §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. Contraceptive coverage must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law…," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	p. 48
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted?	45 CFR § 156.100 §3239 §4328 §3216(l) Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of $200.00 for the subscriber and $100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. *Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.*	p. 56

Yes ☐ No ☒ *Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.* Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.			Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Other Wellness Benefits Is this a Standard Exchange Plan? Yes ☒ No ☐ If yes, Additional Wellness Benefits may not be offered.	45 CFR § 156.100 §3239 §4328 §3216(l)	Additional Wellness Benefits may not be covered under a standard Exchange plan but may be covered under a non-standard Exchange plans. All additional wellness benefits must comply with § 3239 of Insurance Law.	
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric vision care including: emergency, preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 57
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☒ No ☐ Is dental coverage being	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 58, 59

provided by this QHP filing? Yes ☐ No ☐			
Explanation:			
ADDITIONAL BENEFITS		**Additional benefits may be covered in the non-standard Exchange plans only.**	
Family Vision Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	
Orthotics Model Language Used? Yes ☐ No ☒	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	
Explanation:			
Acupuncture		This policy or contract form provides coverage for acupuncture.	Not listed
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	p. 60
Convalescent and Custodial Care	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	

Model Language Used? Yes ☒ No ☐		Necessary.	p. 60
Cosmetic Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	p. 60
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	p. 60
Dental Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	p. 60
Experimental or Investigational Treatment. Model Language Used? Yes ☒ No ☐	§ 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.	p. 60
Felony Participation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	p. 60
Foot Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(6) .Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	p. 61
Government Facility Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	p. 61
Medically Necessary Model Language Used?	§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	

Yes ☒ No ☐		certified by the State.	p. 61
Medicare or Other Governmental Program Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	p. 61
Military Service Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	p. 61
No-Fault Automobile Insurance Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	p. 61
Services Separately Billed by Hospital Employees Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	p. 61
Services Provided by a Family Member Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	p. 61
Services With No Charge Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	p. 61
Services not Listed Model Language Used? Yes ☒ No ☐	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	p. 61
Vision Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	p. 61
Workers' Compensation	11NYCRR52.16(c)(8)	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.	

Model Language Used? Yes ☒ No ☐	Model Language		pp. 61, 62
War Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	p. 62
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E)	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. 63
Submission of Claim Model Language Used? Yes ☒ No ☐	§3216(d)(1)(G) §4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	p. 63
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(g) PHL § 4408-a 10NYCRR98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • 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.	pp. 65, 66
Utilization Review Policies and Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136	This policy or contract form includes a description of the utilization review policies and procedures, including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration;	pp. 67-70

	Model Language	• the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	
External Appeal Procedures Model Language Used? Yes ☒ No ☐	Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	This policy or contract form includes a description of the external appeal procedures, including: • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal.	pp. 71-74
TERMINATION OF COVERAGE Model Language Used? Yes ☒ No ☐	Model Language §4306(c) §4304(c)	*The following are the only termination provisions permissible under the Insurance Law.* *The model language must be used for each of the following termination provisions.*	Form/Page/Para Reference
Notice of Termination		Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	p. 75, paras 2, 3
Termination for Failure to Pay Premiums	§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments. Insurers provide a grace period of at least three consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one full month's premium during the benefit year.	p. 75, para 3. a
Reinstatement Following Default	§4306(g)	Contracts subject to Article 43 include a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	p. 75, para 3. b

Discontinuation of a Class of Coverage	§4304(c)(2)(C) §3216(g)(1)(F)(2)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each subscriber and beneficiary not less than 90 days for plans subject to Article 32 of the Insurance Law, or 5 months for plans subject to Article 43, prior to the date of discontinuance. The insurer must offer individuals the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those individuals or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	p. 76, para 3. e
Discontinuation of all Policies/Contracts in the Individual Market (Applicable to non-HMOs only)	§4304(c)(2)(C)(ii) §3216(g)(1)(D)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the individual market upon written notice to the superintendent and to each subscriber, participant, and beneficiary at least 180 days prior to the date of discontinuance.	p. 76, para 3. f
Termination if there are No Longer Insureds in the Insurer's Service Area	§4304(c)(2)(D) §3216(g)(1)(E)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	Provision not included.
Termination for Spouses in cases of divorce	§3216(g)(1)(F)	This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	p. 75, para 1. b
Termination upon death of Subscriber	§3216(g)(1)(F)	This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	p. 75, para 1. a
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.	p. 75, para 2
Rescission Model Language Used? Yes ☐ No ☒	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	No provision for rescission
Renewal	§3216(g) §4304(b)(2) 11 NYCRR 52.17(a)(2)	This policy or contract provides that except as specified in §3216(g), or §4304(b)(2) the insurer must renew or continue in force such coverage at the option of the subscriber. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	p. 82, para 18
Premiums	§4306(a) §3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	Not group coverage
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits	11 NYCRR	This policy or contract form provides that when coverage under this policy or contract form ends,	

Model Language Used? Yes ☒ No ☐	52.17(a)(15) Model Language	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, 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.	p. 77
Suspension of Coverage Model Language Used? Yes ☒ No ☐	§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.	p. 79
Conversion - Right to a New Contract After Termination Model Language Used? Yes ☒ No ☐	§4306(i) §3216(c)(5)	This policy or contract form provides that (a) if an individual is no longer covered under a "family policy or contract" because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e, bronze, silver, gold, or platinum) that covers all benefits required by state and federal law. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the "family policy or contract" or whose young adult coverage terminates. Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.	p. 78
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes ☒ No ☐	§4306 §3216(d)(1)(B)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	p. 81, para 10

Changes Model Language Used? Yes ☒ No ☐	§4306(e) §3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	p. 84, para 30
Action in Law or Equity Model Language Used? Yes ☒ No ☐	PHL §4406-a §3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three years following the time such proof of loss is required by the policy or contract.	p. 84, para 26
Subrogation Model Language Used? Yes ☒ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	pp. 83, 84, para 25
Unilateral Modification Model Language Used? Yes ☒ No ☐	11 NYCRR52.17 (a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	p. 80, para 3
Non-English Speaking Insureds Model Language Used? Yes ☒ No ☐	PHL §4408(1)(p) §3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	p. 84, para 27
SCHEDULE OF BENEFITS Model Language Used? Yes ☒ No ☐	Standard Benefit Design Description Chart 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. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§4328 §4306-e §3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	No lifetime dollar limits on essential health benefits
Limitations on Annual Dollar Limits Model Language Used? Yes ☒ No ☐	§4328 §3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	No restricted annual dollar limits for essential health benefits

	Model Language		
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.	Yes
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☒ No ☐ If Out-of-Network coverage is offered please answer the following: Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☒	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	EXER-2
Extended Dependent Coverage Model Language Used? Yes ☒ No ☐	§4304(d)(1)(B) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the subscriber or policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 3216(a)(4)(C) or 4304(d)(1)(B).	EXER-1
PROVIDER NETWORKS	§3201(c)	The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF.** *Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.*	

		For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Individual: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio %.	
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: _____ %.	
RATE MANUAL	11NYCRR52.40(c)(2) §3231(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

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

		e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Individual Health Benefits Exchange Checklist

As of 4/09/13

Instructions for SERFF Checklist:

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

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

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

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

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

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Individual Health Benefits Exchange Checklist

LINE OF BUSINESS: **Individual Exchange**

TOI	LINE(S) OF INSURANCE	Sub-TOI
HOrg021	Individual Health Organization Health Maintenance (HMO)	HOrg021.005B Individual POS HOrg021.005D Individual HMO
Individual Health	Major Medical	H161.005A Individual PPO H161.005C Individual Other
Individual Health	Hospital Surgical Medical Expense	H15I.001 Health
H06	Health Conversion	H06.000 Conversion

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

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

		No agent or representative of such corporation and no broker, other than an officer or officers designated therin, is authorized to change the contract or waive any of its provisions. *Note: If this contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the insurer a part of the contract, such portion shall be set forth in full.* If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☐ No ☐ (If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF.	No strikeouts Form number in lower left-hand corner of cover page In form intended for use No illustrative material Variable material explained in MOVM Form placed on SERFF Form Schedule
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.	Bypassed in SERFF
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF filing description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form 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)	Filing description in SERFF. Refers to Form Schedule tab for list of forms by form number
Discrimination	§2606 §2607 §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, or marital status.	No discriminatory provisions

APPLICATION FORMS Model Application Used? Yes ☐ No ☐	Model Language		Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	Model not yet available
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	
Prohibited Questions and Provisions	§3216(c)(5)(a) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy void. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	EXEC-2 Cover page
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Cover page
Free Look	§4306 §3216(c)(10)	This contract or policy contains a "free look" provision that is for a period of not less than 10 days and not more than 20 days.	Cover page
Brief Statement	§4306(m)	This contract or policy contains a brief description of the contract on its first page.	Cover page
Table of Contents Model Language Used? Yes ☒ No ☐	§ 3102(c)(1)(G) Model Language	A table of contents is required.	pp. 1, 2
DEFINITIONS Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	*Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.*	Form/Page/Para Reference
Services Performed at	§4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or	

Comprehensive Care Center for Eating Disorders	§4328	contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Services not excluded
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	p. 9, paras 3, 4
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☐ No ☒	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	PCP designation not required
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☐ No ☒	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer.	PCP designation not required
Preauthorization			
Preauthorization Requirements Model Language Used?	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b)	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or	

Yes ☒ No ☐	Model Language	$500.00, whichever is less, is permissible.	p. 9, para 5
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes ☒ No ☐	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	pp. 9, 10, para 7
Contact Information Model Language Used? Yes ☒ No ☐	§3217-a(a)(16) §4324(a)(16) PHL§4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	pp. 10, 11, para 8
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes ☐ No ☒	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	p. 12
Specialty Care Provider as PCP Model Language Used? Yes ☐ No ☒	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	PCP designation not required
Standing Referrals Model Language Used? Yes ☐ No ☒	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	PCP designation not required
Specialty Care Center Model Language Used? Yes ☐ No ☒	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	PCP designation not required
Transitional Care When A Provider Leaves the Network	§4804(e) §3217-d(c) §4306-C(c)	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the	

Model Language Used? Yes ☒ No ☐	PHL §4403(6)(e) Model Language	provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	p. 12
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ☒ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	pp. 12, 13
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes ☒ No ☐	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	p. 14, para 2
Reimbursement of Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	p. 15, para 5
Non-Participating Providers and Non-Authorized Services	§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.	

Model Language Used? Yes ☒ No ☐			Cover page
ELIGIBILITY Model Language Used? Yes ☒ No ☐	Model Language	For each of the following eligibility provisions model language must be used.	Form/Page/Para Reference
Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	Not applicable
Spouse	§4235(f)(1)(A) §4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	Not applicable
Dependents	§4235(f)(1)(A)(i) §4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. *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.*	Not applicable
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *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.*	Not applicable
Newborn Infants	§4235(f)(2) §4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the*	p. 18

		insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.	
Adopted Children and Step-Children	11NYCRR52.17(a)(30), (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	p. 16
Domestic Partners	§4235(f)(1)(A) §4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • 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.	Not applicable
Enrollment Periods	45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	pp. 17, 18
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	*The following benefits must be included in the policy or contract form.* **Standard Products:** Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits.	Form/Page/Para Reference

		All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart. **Non-Standard Products:** Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative	
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☒ No ☐	§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	p. 19, para A
Federally Mandated Preventive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	pp. 19, 20

Cervical Cytology Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(15) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	p. 20, para D
Mammography Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes the following coverage for mammography screening for occult breast cancer: • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	p. 20, para E
Family Planning & Reproductive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §4328 §3216(i)(10) §3216(l)	This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 20, 21, para F
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☒ No ☐	§3216(l) §4328 § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals: • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for	p. 21, para G

		osteoporosis. Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance	
Prostate Cancer Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 21, para H
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(24) § 4303(aa) Model Language	**Emergency Medical and Ambulance Services:** This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person's bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person. An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization. **Non-Emergency Ambulance Services:** This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:	pp. 22, 23

		• From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	
Emergency Services Model Language Used? Yes ☒ No ☐	§4328 §4303(a)(2) §3316(i)(9) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be*	pp. 24, 35

		necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).	
Urgent Care Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l)	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	pp. 25, 36
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 27
Allergy Testing and Treatment Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 27
Ambulatory Surgery Center Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 27
Chemotherapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 27
Chiropractic Care Model Language Used? Yes ☒ No ☐	§3216(i)(21) §4328 §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or sublaxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such	p. 27

		amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	
Dialysis Coverage Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.	pp. 27, 28
Outpatient Habilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the*	§4328 §3216(l) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 28

addition of benefits to EHB categories are only permissible in Non-Standard Products. Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.		*Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per condition; cover visits per year rather than per condition; and may remove the lifetime limit.*	Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Home Health Services Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(6) §4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.	p. 28

		Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.	
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. *Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.*	p. 28
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(13) 4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded for Non-Standard Products. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	pp. 28, 29
Infusion Therapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(i)(15-a)(A) §3216(l) 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.	p. 29
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) 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.	p. 29
Office Visits	45 CFR § 156.100	This policy or contract form provides coverage for office visits for the diagnosis and treatment of	

Model Language Used? Yes ☒ No ☐	§4328 §3216(l) Model Language	injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 30
Outpatient Hospital Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 30
Preadmission Testing Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(7) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 30
Outpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more*	pp. 30, 31 Form is for both standard and non-standard products and benefit is the same for both.

this substitution or addition differs from the Standard benefit in the space provided.		*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.*	
Non-Standard Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(19)(A)(i) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 31
Second Surgical Opinion Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(8) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 31
Mandatory Second Surgical Opinion Model Language Used? Yes ☒ No ☐	4303(b) §4328 Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	p. 31
Second Opinion in Other Cases Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 31
Surgical Services	45 CFR § 156.100 §4328	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	

Model Language Used? Yes ☒ No ☐	§3216(l) 11 NYCRR § 52.6 Model Language	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.	pp. 31, 32
Oral Surgery Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) §4328 §3216(l) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Mastectomy Care Model Language Used? Yes ☒ No ☐	§3216(l) §3216(i)(20) §4328 §4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 41
Post Mastectomy Reconstruction Model Language Used? Yes ☒ No ☐	§3216(i)(20) §4328 §4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	p. 32
Transplants	45 CFR § 156.100 §3215(l)	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,	

Model Language Used? Yes ☒ No ☐	§4328 Model Language	and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 32, 33
Autism Spectrum Disorder Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(25) Model Language 11 NYCRR 440	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. This policy or contract form shall include a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy or contract form shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year. The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.	pp. 34-36

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§3216(i)(15-a) §4328 §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3216(i)(15-a) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. *Note: For **Standard Products**, the medical benefit cost-sharing must apply. For **Non-Standard** Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.* *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.*	pp. 36-37
Durable Medical Equipment and Braces Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 37, 38
Hearing Aids Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. *{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}*	p. 38

		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(o) 45 CFR § 156.100 Model Language	This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits. *Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.*	p. 38
Prosthetics Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	External Prosthetic Devices**:** This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.* Internal Prosthetic Devices**:** This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 38, 39

Hospital Services Model Language Used? Yes ☐ No ☐	11NYCRR52.5 45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 40
Maternity Care Model Language Used? Yes ☒ No ☐	§3216(i)(10) §4328 4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3216(i)(10), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.	p. 42

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 41
Inpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. *Note: The Standard Exchange Plan must cover 60 days. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the "per condition" and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	p. 41 Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Skilled Nursing Facility	§3216(i)(6)	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility,	

Model Language Used? Yes ☒ No ☐	§4328 §4303(d) 45 CFR § 156.100 Model Language	including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 41, 42
End of Life Care Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	p. 42
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	§4328 §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, individual policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	p. 43
Outpatient Mental Health Care Services Model Language Used? Yes ☐ No ☐	§3216(i)(4) §4328 §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No.	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.	p. 43

	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	Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
Inpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	p. 43
Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to	This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of	p. 44

	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	opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.* *Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the	pp. 45-53

		same number of prescription drugs in each category and class as the benchmark plan. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Enteral Formulas Model Language Used? Yes ☒ No ☐	§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 45
Off-Label Cancer Drug Usage Model Language Used? Yes ☒ No ☐	§3216(i)(12) §4328 §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	pp. 45, 46
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	p. 47, para 2, p. 48, para 5
Prohibition for Tier IV Drugs	§4328 §3216(l) §4303(gg) PHL §4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	No Tier IV Drug benefits
Eye Drops Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not	p. 46

		limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Orally Administered Anticancer Medications Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(12-a)(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.	p. 50, para 9
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §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.	p. 49, para 8
Contraceptive Drugs and Devices Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §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. Contraceptive coverage must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law…," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	p. 46
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted?	45 CFR § 156.100 §3239 §4328 §3216(l) Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of $200.00 for the subscriber and $100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. *Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.*	p. 54

Yes ☐ No ☒ *Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.* Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.			Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Other Wellness Benefits Is this a Standard Exchange Plan? Yes ☒ No ☐ If yes, Additional Wellness Benefits may not be offered.	45 CFR § 156.100 §3239 §4328 §3216(l)	Additional Wellness Benefits may not be covered under a standard Exchange plan but may be covered under a non-standard Exchange plans. All additional wellness benefits must comply with § 3239 of Insurance Law.	
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric vision care including: emergency, preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 55
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☒ No ☐ Is dental coverage being	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 56, 57

provided by this QHP filing? Yes ☐ No ☐			
Explanation:			
ADDITIONAL BENEFITS		**Additional benefits may be covered in the non-standard Exchange plans only.**	
Family Vision Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	
Orthotics Model Language Used? Yes ☐ No ☒	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	Not applicable
Explanation:			
Acupuncture		This policy or contract form provides coverage for acupuncture.	Not listed
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	p. 58
Convalescent and Custodial Care	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	

Model Language Used? Yes ☒ No ☐		Necessary.	p. 58
Cosmetic Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	p. 58
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	p. 58
Dental Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	p. 58
Experimental or Investigational Treatment. Model Language Used? Yes ☒ No ☐	§ 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.	p. 58
Felony Participation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	p. 58
Foot Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(6) .Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	p. 59
Government Facility Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	p. 59
Medically Necessary Model Language Used?	§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	

Yes ☒ No ☐		certified by the State.	p. 59
Medicare or Other Governmental Program Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	p. 59
Military Service Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	p. 59
No-Fault Automobile Insurance Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	p. 59
Services Separately Billed by Hospital Employees Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	p. 59
Services Provided by a Family Member Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	p. 59
Services With No Charge Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	p. 59
Services not Listed Model Language Used? Yes ☒ No ☐	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	p. 59
Vision Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	p. 59
Workers' Compensation	11NYCRR52.16(c)(8)	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.	

Model Language Used? Yes ☒ No ☐	Model Language		pp. 59, 60
War Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	p. 62
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E)	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. 61
Submission of Claim Model Language Used? Yes ☒ No ☐	§3216(d)(1)(G) §4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	p. 61
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(g) PHL § 4408-a 10NYCRR98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • 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.	pp. 63, 64
Utilization Review Policies and Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136	This policy or contract form includes a description of the utilization review policies and procedures, including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration;	pp. 65-68

	Model Language	• the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	
External Appeal Procedures Model Language Used? Yes ☒ No ☐	Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	This policy or contract form includes a description of the external appeal procedures, including: • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal.	pp. 69-72
TERMINATION OF COVERAGE Model Language Used? Yes ☒ No ☐	Model Language §4306(c) §4304(c)	*The following are the only termination provisions permissible under the Insurance Law.* *The model language must be used for each of the following termination provisions.*	Form/Page/Para Reference
Notice of Termination		Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	p. 73, paras 2, 3
Termination for Failure to Pay Premiums	§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments. Insurers provide a grace period of at least three consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one full month's premium during the benefit year.	p. 73, para 3. a
Reinstatement Following Default	§4306(g)	Contracts subject to Article 43 include a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	p. 73, para 3. b

Discontinuation of a Class of Coverage	§4304(c)(2)(C) §3216(g)(1)(F)(2)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each subscriber and beneficiary not less than 90 days for plans subject to Article 32 of the Insurance Law, or 5 months for plans subject to Article 43, prior to the date of discontinuance. The insurer must offer individuals the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those individuals or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	p. 74, para 3. d
Discontinuation of all Policies/Contracts in the Individual Market (Applicable to non-HMOs only)	§4304(c)(2)(C)(ii) §3216(g)(1)(D)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the individual market upon written notice to the superintendent and to each subscriber, participant, and beneficiary at least 180 days prior to the date of discontinuance.	p. 74, para 3. e
Termination if there are No Longer Insureds in the Insurer's Service Area	§4304(c)(2)(D) §3216(g)(1)(E)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	Provision not included.
Termination for Spouses in cases of divorce	§3216(g)(1)(F)	This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	Not applicable
Termination upon death of Subscriber	§3216(g)(1)(F)	This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	p. 73, para 1. a
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.	p. 73, para 2
Rescission Model Language Used? Yes ☐ No ☒	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	No provision for rescission
Renewal	§3216(g) §4304(b)(2) 11 NYCRR 52.17(a)(2)	This policy or contract provides that except as specified in §3216(g), or §4304(b)(2) the insurer must renew or continue in force such coverage at the option of the subscriber. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	p. 80, para 18
Premiums	§4306(a) §3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	Not group coverage
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits	11 NYCRR	This policy or contract form provides that when coverage under this policy or contract form ends,	

Model Language Used? Yes ☒ No ☐	52.17(a)(15) Model Language	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, 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.	p. 75
Suspension of Coverage Model Language Used? Yes ☒ No ☐	§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.	p. 77
Conversion - Right to a New Contract After Termination Model Language Used? Yes ☒ No ☐	§4306(i) §3216(c)(5)	This policy or contract form provides that (a) if an individual is no longer covered under a "family policy or contract" because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e, bronze, silver, gold, or platinum) that covers all benefits required by state and federal law. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the "family policy or contract" or whose young adult coverage terminates. Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.	p. 76
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes ☒ No ☐	§4306 §3216(d)(1)(B)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	p. 79, para 10

Changes Model Language Used? Yes ☒ No ☐	§4306(e) §3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	p. 82, para 30
Action in Law or Equity Model Language Used? Yes ☒ No ☐	PHL §4406-a §3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three years following the time such proof of loss is required by the policy or contract.	p. 82, para 26
Subrogation Model Language Used? Yes ☒ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	pp. 81, 82, para 25
Unilateral Modification Model Language Used? Yes ☒ No ☐	11 NYCRR52.17 (a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	p. 78, para 3
Non-English Speaking Insureds Model Language Used? Yes ☒ No ☐	PHL §4408(1)(p) §3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	p. 82, para 27
SCHEDULE OF BENEFITS Model Language Used? Yes ☒ No ☐	Standard Benefit Design Description Chart 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. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§4328 §4306-e §3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	No lifetime dollar limits on essential health benefits
Limitations on Annual Dollar Limits Model Language Used? Yes ☒ No ☐	§4328 §3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	No restricted annual dollar limits for essential health benefits

	Model Language		
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.	Yes
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☒ No ☐ If Out-of-Network coverage is offered please answer the following: Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☒	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	EXER-2
Extended Dependent Coverage Model Language Used? Yes ☐ No ☒	§4304(d)(1)(B) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the subscriber or policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 3216(a)(4)(C) or 4304(d)(1)(B).	Not applicable
PROVIDER NETWORKS	§3201(c)	The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF.** *Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.*	

		For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Individual: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio %.	
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: _____ %.	
RATE MANUAL	11NYCRR52.40(c)(2) §3231(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

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

		e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Individual Health Benefits Exchange Checklist

As of 4/09/13

Instructions for SERFF Checklist:

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

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

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

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

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

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Individual Health Benefits Exchange Checklist

LINE OF BUSINESS: **Individual Exchange**

TOI	LINE(S) OF INSURANCE	Sub-TOI
HOrg021	Individual Health Organization Health Maintenance (HMO)	HOrg021.005B Individual POS HOrg021.005D Individual HMO
Individual Health	Major Medical	H161.005A Individual PPO H161.005C Individual Other
Individual Health	Hospital Surgical Medical Expense	H15I.001 Health
H06	Health Conversion	H06.000 Conversion

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

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

		No agent or representative of such corporation and no broker, other than an officer or officers designated therin, is authorized to change the contract or waive any of its provisions. *Note: If this contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the insurer a part of the contract, such portion shall be set forth in full.* If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☐ No ☐ (If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF.	No strikeouts Form number in lower left-hand corner of cover page In form intended for use No illustrative material Variable material explained in MOVM Form placed on SERFF Form Schedule
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.	Bypassed in SERFF
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF filing description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form 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)	Filing description in SERFF. Refers to Form Schedule tab for list of forms by form number
Discrimination	§2606 §2607 §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, or marital status.	No discriminatory provisions

APPLICATION FORMS Model Application Used? Yes ☐ No ☐	Model Language		Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	Model not yet available
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	
Prohibited Questions and Provisions	§3216(c)(5)(a) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy void. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	EXEC-3 Cover page
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Cover page
Free Look	§4306 §3216(c)(10)	This contract or policy contains a "free look" provision that is for a period of not less than 10 days and not more than 20 days.	Cover page
Brief Statement	§4306(m)	This contract or policy contains a brief description of the contract on its first page.	Cover page
Table of Contents Model Language Used? Yes ☒ No ☐	§ 3102(c)(1)(G) Model Language	A table of contents is required.	pp. 1, 2
DEFINITIONS Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	*Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.*	Form/Page/Para Reference
Services Performed at	§4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or	

Comprehensive Care Center for Eating Disorders	§4328	contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Services not excluded
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	p. 9, paras 3, 4
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☐ No ☒	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	PCP designation not required
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☐ No ☒	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer.	PCP designation not required
Preauthorization			
Preauthorization Requirements Model Language Used?	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b)	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or	

Yes ☒ No ☐	Model Language	$500.00, whichever is less, is permissible.	p. 9, para 5
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes ☒ No ☐	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	pp. 9, 10, para 7
Contact Information Model Language Used? Yes ☒ No ☐	§3217-a(a)(16) §4324(a)(16) PHL§4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	pp. 10, 11, para 8
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes ☐ No ☒	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	p. 12
Specialty Care Provider as PCP Model Language Used? Yes ☐ No ☒	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	PCP designation not required
Standing Referrals Model Language Used? Yes ☐ No ☒	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	PCP designation not required
Specialty Care Center Model Language Used? Yes ☐ No ☒	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	PCP designation not required
Transitional Care When A Provider Leaves the Network	§4804(e) §3217-d(c) §4306-C(c)	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the	

Model Language Used? Yes ☒ No ☐	PHL §4403(6)(e) Model Language	provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	p. 12
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ☒ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	pp. 12, 13
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes ☒ No ☐	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	p. 14, para 2
Reimbursement of Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	p. 15, para 6
Non-Participating Providers and Non-Authorized Services	§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.	

Model Language Used? Yes ☒ No ☐			Cover page
ELIGIBILITY Model Language Used? Yes ☒ No ☐	Model Language	For each of the following eligibility provisions model language must be used.	Form/Page/Para Reference
Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	p. 16
Spouse	§4235(f)(1)(A) §4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	p. 16, model language used
Dependents	§4235(f)(1)(A)(i) §4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. *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.*	p. 16
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *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.*	p. 17
Newborn Infants	§4235(f)(2) §4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the*	p. 18

		insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.	
Adopted Children and Step-Children	11NYCRR52.17(a)(30), (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	p. 16
Domestic Partners	§4235(f)(1)(A) §4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • 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.	pp. 19, 20
Enrollment Periods	45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	pp. 17, 18
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	*The following benefits must be included in the policy or contract form.* **Standard Products:** Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits.	Form/Page/Para Reference

		All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart. **Non-Standard Products:** Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative	
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☒ No ☐	§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	p. 21, para A
Federally Mandated Preventive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	pp. 21, 22

Cervical Cytology Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(15) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	p. 22, para D
Mammography Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes the following coverage for mammography screening for occult breast cancer: • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	p. 22, para E
Family Planning & Reproductive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §4328 §3216(i)(10) §3216(l)	This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 22, 23, para F
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☒ No ☐	§3216(l) §4328 § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals: • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for	p. 23, para G

		osteoporosis. Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance	
Prostate Cancer Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 23, para H
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(24) § 4303(aa) Model Language	**Emergency Medical and Ambulance Services:** This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person's bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person. An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization. **Non-Emergency Ambulance Services:** This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:	pp. 24, 25

		• From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	
Emergency Services Model Language Used? Yes ☒ No ☐	§4328 §4303(a)(2) §3316(i)(9) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be*	pp. 26, 27

		necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).	
Urgent Care Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l)	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	pp. 27, 28
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Allergy Testing and Treatment Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Ambulatory Surgery Center Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Chemotherapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Chiropractic Care Model Language Used? Yes ☒ No ☐	§3216(i)(21) §4328 §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or sublaxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such	p. 29

		amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	
Dialysis Coverage Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.	pp. 29, 30
Outpatient Habilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the*	§4328 §3216(l) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 30

addition of benefits to EHB categories are only permissible in Non-Standard Products. Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.		*Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per condition; cover visits per year rather than per condition; and may remove the lifetime limit.*	Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Home Health Services Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(6) §4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.	p. 30

		Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.	
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. *Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.*	p. 30
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(13) 4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded for Non-Standard Products. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	pp. 30, 31
Infusion Therapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(i)(15-a)(A) §3216(l) 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.	p. 31
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) 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.	p. 31
Office Visits	45 CFR § 156.100	This policy or contract form provides coverage for office visits for the diagnosis and treatment of	

Model Language Used? Yes ☒ No ☐	§4328 §3216(l) Model Language	injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Outpatient Hospital Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Preadmission Testing Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(7) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Outpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more*	pp. 32, 33 Form is for both standard and non-standard products and benefit is the same for both.

this substitution or addition differs from the Standard benefit in the space provided.		*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.*	
Non-Standard Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(19)(A)(i) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 33
Second Surgical Opinion Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(8) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 33
Mandatory Second Surgical Opinion Model Language Used? Yes ☒ No ☐	4303(b) §4328 Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	p. 33
Second Opinion in Other Cases Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 33
Surgical Services	45 CFR § 156.100 §4328	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	

Model Language Used? Yes ☒ No ☐	§3216(l) 11 NYCRR § 52.6 Model Language	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.	pp. 33, 34
Oral Surgery Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) §4328 §3216(l) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 34
Mastectomy Care Model Language Used? Yes ☒ No ☐	§3216(l) §3216(i)(20) §4328 §4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 43
Post Mastectomy Reconstruction Model Language Used? Yes ☒ No ☐	§3216(i)(20) §4328 §4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	p. 34
Transplants	45 CFR § 156.100 §3215(l)	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,	

Model Language Used? Yes ☒ No ☐	§4328 Model Language	and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 34, 35
Autism Spectrum Disorder Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(25) Model Language 11 NYCRR 440	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. This policy or contract form shall include a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy or contract form shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year. The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.	pp. 36-38

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§3216(i)(15-a) §4328 §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3216(i)(15-a) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. *Note: For **Standard Products**, the medical benefit cost-sharing must apply. For **Non-Standard** Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.* *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.*	pp. 38-39
Durable Medical Equipment and Braces Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 39, 40
Hearing Aids Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. *{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}*	p. 40

		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(o) 45 CFR § 156.100 Model Language	This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits. *Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.*	p. 40
Prosthetics Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	External Prosthetic Devices**:** This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.* Internal Prosthetic Devices**:** This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 40, 41

Hospital Services Model Language Used? Yes ☐ No ☐	11NYCRR52.5 45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 42
Maternity Care Model Language Used? Yes ☒ No ☐	§3216(i)(10) §4328 4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3216(i)(10), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.	p. 43

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 43
Inpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. *Note: The Standard Exchange Plan must cover 60 days. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the "per condition" and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	p. 43 Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Skilled Nursing Facility	§3216(i)(6)	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility,	

Model Language Used? Yes ☒ No ☐	§4328 §4303(d) 45 CFR § 156.100 Model Language	including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 43
End of Life Care Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	p. 44
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	§4328 §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, individual policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	p. 45
Outpatient Mental Health Care Services Model Language Used? Yes ☐ No ☐	§3216(i)(4) §4328 §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No.	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.	p. 45

	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	Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
Inpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	p. 45
Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to	This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of	p. 46

	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	opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.* *Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the	pp. 47-55

		same number of prescription drugs in each category and class as the benchmark plan. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Enteral Formulas Model Language Used? Yes ☒ No ☐	§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 47
Off-Label Cancer Drug Usage Model Language Used? Yes ☒ No ☐	§3216(i)(12) §4328 §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	pp. 47, 48
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	p. 49, para 2, p. 50, para 5
Prohibition for Tier IV Drugs	§4328 §3216(l) §4303(gg) PHL §4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	No Tier IV Drug benefits
Eye Drops Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not	p. 48

		limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Orally Administered Anticancer Medications Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(12-a)(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.	pp. 51, 52, para 9
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §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.	p. 51, para 8
Contraceptive Drugs and Devices Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §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. Contraceptive coverage must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law…," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	p. 48
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted?	45 CFR § 156.100 §3239 §4328 §3216(l) Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of $200.00 for the subscriber and $100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. *Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.*	p. 56

Yes ☐ No ☒ *Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.* Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.			Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Other Wellness Benefits Is this a Standard Exchange Plan? Yes ☒ No ☐ If yes, Additional Wellness Benefits may not be offered.	45 CFR § 156.100 §3239 §4328 §3216(l)	Additional Wellness Benefits may not be covered under a standard Exchange plan but may be covered under a non-standard Exchange plans. All additional wellness benefits must comply with § 3239 of Insurance Law.	
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric vision care including: emergency, preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 57
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☒ No ☐ Is dental coverage being	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 58, 59

provided by this QHP filing? Yes ☐ No ☐			
Explanation:			
ADDITIONAL BENEFITS		**Additional benefits may be covered in the non-standard Exchange plans only.**	
Family Vision Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	
Orthotics Model Language Used? Yes ☐ No ☒	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	
Explanation:			
Acupuncture		This policy or contract form provides coverage for acupuncture.	Not listed
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	p. 60
Convalescent and Custodial Care	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	

Model Language Used? Yes ☒ No ☐		Necessary.	p. 60
Cosmetic Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	p. 60
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	p. 60
Dental Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	p. 60
Experimental or Investigational Treatment. Model Language Used? Yes ☒ No ☐	§ 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.	p. 60
Felony Participation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	p. 60
Foot Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(6) .Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	p. 61
Government Facility Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	p. 61
Medically Necessary Model Language Used?	§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	

Yes ☒ No ☐		certified by the State.	p. 61
Medicare or Other Governmental Program Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	p. 61
Military Service Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	p. 61
No-Fault Automobile Insurance Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	p. 61
Services Separately Billed by Hospital Employees Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	p. 61
Services Provided by a Family Member Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	p. 61
Services With No Charge Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	p. 61
Services not Listed Model Language Used? Yes ☒ No ☐	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	p. 61
Vision Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	p. 61
Workers' Compensation	11NYCRR52.16(c)(8)	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.	

Model Language Used? Yes ☒ No ☐	Model Language		pp. 61, 62
War Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	p. 62
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E)	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. 63
Submission of Claim Model Language Used? Yes ☒ No ☐	§3216(d)(1)(G) §4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	p. 63
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(g) PHL § 4408-a 10NYCRR98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • 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.	pp. 65, 66
Utilization Review Policies and Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136	This policy or contract form includes a description of the utilization review policies and procedures, including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration;	pp. 67-70

	Model Language	• the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	
External Appeal Procedures Model Language Used? Yes ☒ No ☐	Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	This policy or contract form includes a description of the external appeal procedures, including: • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal.	pp. 71-74
TERMINATION OF COVERAGE Model Language Used? Yes ☒ No ☐	Model Language §4306(c) §4304(c)	*The following are the only termination provisions permissible under the Insurance Law.* *The model language must be used for each of the following termination provisions.*	Form/Page/Para Reference
Notice of Termination		Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	p. 75, paras 2, 3
Termination for Failure to Pay Premiums	§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments. Insurers provide a grace period of at least three consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one full month's premium during the benefit year.	p. 75, para 3. a
Reinstatement Following Default	§4306(g)	Contracts subject to Article 43 include a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	p. 75, para 3. b

Discontinuation of a Class of Coverage	§4304(c)(2)(C) §3216(g)(1)(F)(2)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each subscriber and beneficiary not less than 90 days for plans subject to Article 32 of the Insurance Law, or 5 months for plans subject to Article 43, prior to the date of discontinuance. The insurer must offer individuals the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those individuals or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	p. 75, para 3. e
Discontinuation of all Policies/Contracts in the Individual Market (Applicable to non-HMOs only)	§4304(c)(2)(C)(ii) §3216(g)(1)(D)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the individual market upon written notice to the superintendent and to each subscriber, participant, and beneficiary at least 180 days prior to the date of discontinuance.	p. 76, para 3. f
Termination if there are No Longer Insureds in the Insurer's Service Area	§4304(c)(2)(D) §3216(g)(1)(E)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	Provision not included.
Termination for Spouses in cases of divorce	§3216(g)(1)(F)	This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	p. 75, para 1. b
Termination upon death of Subscriber	§3216(g)(1)(F)	This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	p. 75, para 1. a
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.	p. 75, para 2
Rescission Model Language Used? Yes ☐ No ☒	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	No provision for rescission
Renewal	§3216(g) §4304(b)(2) 11 NYCRR 52.17(a)(2)	This policy or contract provides that except as specified in §3216(g), or §4304(b)(2) the insurer must renew or continue in force such coverage at the option of the subscriber. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	p. 82, para 18
Premiums	§4306(a) §3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	Not group coverage
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits	11 NYCRR	This policy or contract form provides that when coverage under this policy or contract form ends,	

Model Language Used? Yes ☒ No ☐	52.17(a)(15) Model Language	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, 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.	p. 77
Suspension of Coverage Model Language Used? Yes ☒ No ☐	§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.	p. 79
Conversion - Right to a New Contract After Termination Model Language Used? Yes ☒ No ☐	§4306(i) §3216(c)(5)	This policy or contract form provides that (a) if an individual is no longer covered under a "family policy or contract" because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e, bronze, silver, gold, or platinum) that covers all benefits required by state and federal law. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the "family policy or contract" or whose young adult coverage terminates. Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.	p. 78
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes ☒ No ☐	§4306 §3216(d)(1)(B)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	p. 81, para 10

Changes Model Language Used? Yes ☒ No ☐	§4306(e) §3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	p. 84, para 30
Action in Law or Equity Model Language Used? Yes ☒ No ☐	PHL §4406-a §3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three years following the time such proof of loss is required by the policy or contract.	p. 84, para 26
Subrogation Model Language Used? Yes ☒ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	pp. 83, 84, para 25
Unilateral Modification Model Language Used? Yes ☒ No ☐	11 NYCRR52.17 (a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	p. 80, para 3
Non-English Speaking Insureds Model Language Used? Yes ☒ No ☐	PHL §4408(1)(p) §3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	p. 84, para 27
SCHEDULE OF BENEFITS Model Language Used? Yes ☒ No ☐	Standard Benefit Design Description Chart 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. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§4328 §4306-e §3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	No lifetime dollar limits on essential health benefits
Limitations on Annual Dollar Limits Model Language Used? Yes ☒ No ☐	§4328 §3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	No restricted annual dollar limits for essential health benefits

	Model Language		
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.	Yes
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☒ No ☐ If Out-of-Network coverage is offered please answer the following: Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☒	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	EXER-2
Extended Dependent Coverage Model Language Used? Yes ☒ No ☐	§4304(d)(1)(B) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the subscriber or policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 3216(a)(4)(C) or 4304(d)(1)(B).	EXER-1
PROVIDER NETWORKS	§3201(c)	The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF.** *Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.*	

		For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Individual: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio %.	
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: _____ %.	
RATE MANUAL	11NYCRR52.40(c)(2) §3231(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

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

		e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Individual Health Benefits Exchange Checklist

As of 4/09/13

Instructions for SERFF Checklist:

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

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

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

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

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

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

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

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Individual Health Benefits Exchange Checklist

LINE OF BUSINESS: **Individual Exchange**

TOI	LINE(S) OF INSURANCE	Sub-TOI
HOrg021	Individual Health Organization Health Maintenance (HMO)	HOrg021.005B Individual POS HOrg021.005D Individual HMO
Individual Health	Major Medical	H161.005A Individual PPO H161.005C Individual Other
Individual Health	Hospital Surgical Medical Expense	H15I.001 Health
H06	Health Conversion	H06.000 Conversion

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

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

		No agent or representative of such corporation and no broker, other than an officer or officers designated therin, is authorized to change the contract or waive any of its provisions. *Note: If this contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the insurer a part of the contract, such portion shall be set forth in full.* If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☐ No ☐ (If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. §52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. §52.31(l) • All policy or contract forms must be placed on the Form Schedule in SERFF.	No strikeouts Form number in lower left-hand corner of cover page In form intended for use No illustrative material Variable material explained in MOVM Form placed on SERFF Form Schedule
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.	Bypassed in SERFF
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF filing description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form 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)	Filing description in SERFF. Refers to Form Schedule tab for list of forms by form number
Discrimination	§2606 §2607 §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, or marital status.	No discriminatory provisions

APPLICATION FORMS Model Application Used? Yes ☐ No ☐	Model Language		Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	Model not yet available
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	
Prohibited Questions and Provisions	§3216(c)(5)(a) §3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy void. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	EXEC-4 Cover page
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	Cover page
Free Look	§4306 §3216(c)(10)	This contract or policy contains a "free look" provision that is for a period of not less than 10 days and not more than 20 days.	Cover page
Brief Statement	§4306(m)	This contract or policy contains a brief description of the contract on its first page.	Cover page
Table of Contents Model Language Used? Yes ☒ No ☐	§ 3102(c)(1)(G) Model Language	A table of contents is required.	pp. 1, 2
DEFINITIONS Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	*Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.*	Form/Page/Para Reference
Services Performed at	§4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or	

Comprehensive Care Center for Eating Disorders	§4328	contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	Services not excluded
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	p. 9, paras 3, 4
Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☐ No ☒	§3217-e §4306-d PHL §4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	PCP designation not required
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes ☐ No ☒ Model Language Used? Yes ☐ No ☒	§3217-c §4306-b(a) §4324(16-a) PHL §4406-b PHL §4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If the policy or contract requires the designation of a Primary Care Provider, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • such qualified provider agrees to adhere to the insurer's policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer.	PCP designation not required
Preauthorization			
Preauthorization Requirements Model Language Used?	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b)	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or	

Yes ☒ No ☐	Model Language	$500.00, whichever is less, is permissible.	p. 9, para 5
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes ☒ No ☐	§3217-a(a)(1) §4324(a)(1) §4408(1)(a) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	pp. 9, 10, para 8
Contact Information Model Language Used? Yes ☒ No ☐	§3217-a(a)(16) §4324(a)(16) PHL§4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	pp. 10, 11, para 9
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes ☐ No ☒	§3217-a(a)(11) §4324(a)(11) PHL §4408(1)(k) §4403(6)(a) Model Language	If a policy or contract form is a managed care product as defined in §4801(c) or an HMO, or an EPO it must describe how an insured may obtain a referral to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	p. 12
Specialty Care Provider as PCP Model Language Used? Yes ☐ No ☒	§3217-a(a)(13) §3217-d(b) §4324(a)(13) §4306-C(b) PHL §4408(1)(m) PHL §4403(6)(c) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	PCP designation not required
Standing Referrals Model Language Used? Yes ☐ No ☒	§3217-a(a)(12) §3217-d(b) §4324(a)(12) §4306-C(b) PHL § 4408(1)(l) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	PCP designation not required
Specialty Care Center Model Language Used? Yes ☐ No ☒	§3217-a(a)(14) §3217-d(b) §4324(a)(14) §4306-C(b) PHL §4408(1)(n) PHL §4403(6)(d) Model Language	If this policy or contract form requires (1) the designation of a PCP, and (2) that specialty care must be provided pursuant referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	PCP designation not required
Transitional Care When A Provider Leaves the Network	§4804(e) §3217-d(c) §4306-C(c)	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the	

Model Language Used? Yes ☒ No ☐	PHL §4403(6)(e) Model Language	provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	p. 12
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ☒ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	pp. 12, 13
COST-SHARING EXPENSES AND ALLOWED AMOUNT.			
Cost of Service Model Language Used? Yes ☒ No ☐	§3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	p. 14, para 2
Reimbursement of Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(4) §4324(a)(4) PHL §4408(1)(d) Model Language	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	p. 15, para 5
Non-Participating Providers and Non-Authorized Services	§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.	

Model Language Used? Yes ☒ No ☐			Cover page
ELIGIBILITY Model Language Used? Yes ☒ No ☐	Model Language	For each of the following eligibility provisions model language must be used.	Form/Page/Para Reference
Person to Whom Contract is Issued	§4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	p. 16
Spouse	§4235(f)(1)(A) §4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	p. 16, model language used
Dependents	§4235(f)(1)(A)(i) §4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. *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.*	p. 16
Unmarried Disabled Children	§4235(f)(1)(A)(ii) §4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *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.*	p. 16
Newborn Infants	§4235(f)(2) §4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the*	p. 18

		insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.	
Adopted Children and Step-Children	11NYCRR52.17(a)(30), (31)	For Parent and Child/Children and/or Family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	p. 16
Domestic Partners	§4235(f)(1)(A) §4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • 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.	pp. 19, 20
Enrollment Periods	45 C.F.R. § 155.410 45 C.F.R. § 155.420 45 C.F.R. § 155.305 45 C.F.R. § 155.725 Model Language	This policy or contract form must provide for an initial open enrollment period, an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	pp. 17, 18
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	*The following benefits must be included in the policy or contract form.* **Standard Products:** Insurers may not (i) substitute benefits; (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits.	Form/Page/Para Reference

		All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart. **Non-Standard Products:** Insurers may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative	
Benefits and Exclusions	§4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☒ No ☐	§4328 §4303(j), (p), (t) §3216(i)(17) §3216(l) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	p. 21, para A
Federally Mandated Preventive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	pp. 21, 22

Cervical Cytology Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(15) § 4303(t) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	p. 22, para D
Mammography Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes the following coverage for mammography screening for occult breast cancer: • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	p. 22, para E
Family Planning & Reproductive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §4328 §3216(i)(10) §3216(l)	This policy or contract form includes coverage for family planning services which consist of FDA approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 22, 23, para F
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☒ No ☐	§3216(l) §4328 § 4303(bb) 42 USC § 300gg-13 45 CFR §147.130 Model Language	This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals: • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for	p. 23, para G

		osteoporosis. Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance	
Prostate Cancer Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(k)(11-a)(A) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 23, para H
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(24) § 4303(aa) Model Language	**Emergency Medical and Ambulance Services:** This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service (either ground, water or air) issued a certificate to operate pursuant to §3005 of the Public Health Law. This policy or contract form will, however, only provide coverage when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (i) Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) Serious impairment to such person's bodily functions; (iii) Serious dysfunction of any bodily organ or part of such person; or (iv) Serious disfigurement of such person. An ambulance service may not charge or seek reimbursement from the insured for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable copayment, coinsurance, or deductible. Pre-Hospital Emergency Medical Services and ambulance services for medical emergencies do not require preauthorization. **Non-Emergency Ambulance Services:** This policy or contract form covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:	pp. 24, 25

		• From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	
Emergency Services Model Language Used? Yes ☒ No ☐	§4328 §4303(a)(2) §3316(i)(9) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) Circular Letter No.1 (2002) PHL § 4408(1)(h) 10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR §147.138(b) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be*	pp. 26, 27

		necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).	
Urgent Care Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l)	This policy or contract form includes coverage for Urgent Care. Urgent Care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	pp. 27, 28
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Allergy Testing and Treatment Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Ambulatory Surgery Center Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for surgical procedures performed at an Ambulatory Surgical Center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Chemotherapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 29
Chiropractic Care Model Language Used? Yes ☒ No ☐	§3216(i)(21) §4328 §4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or sublaxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such	p. 29

		amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	
Dialysis Coverage Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4303(gg) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. Benefits for services of a Non-Participating Provider are subject to any applicable cost sharing that applies to dialysis treatments by a Participating Provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.	pp. 29, 30
Outpatient Habilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the*	§4328 §3216(l) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 30

addition of benefits to EHB categories are only permissible in Non-Standard Products. Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.		*Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more visits per condition; cover visits per year rather than per condition; and may remove the lifetime limit.*	Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Home Health Services Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(6) §4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit Such coverage may be subject to an annual deductible of not more than $50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.	p. 30

		Note: Standard Exchange Plans must cover 40 visits. Non-standard Exchange plans may increase the number of covered home health care visits.	
Interruption of Pregnancy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one procedure per Member, per Year. *Note: Plans must include the one procedure limit for the Standard Exchange plan and may provide coverage that is more favorable for the Non-standard exchange plans.*	p. 30
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(13) 4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded for Non-Standard Products. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	pp. 30, 31
Infusion Therapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(i)(15-a)(A) §3216(l) 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.	p. 31
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) 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.	p. 31
Office Visits	45 CFR § 156.100	This policy or contract form provides coverage for office visits for the diagnosis and treatment of	

Model Language Used? Yes ☒ No ☐	§4328 §3216(l) Model Language	injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Outpatient Hospital Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(i)(5) §3216(l) Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Preadmission Testing Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(7) §4303(a)(1) Model Language	This policy or contract form includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 32
Outpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form includes coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits per condition, per lifetime. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.* Speech and physical therapy is covered only when: such therapy are related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this includes a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury. Speech, physical and occupational therapy services must begin within six months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date You are discharged from a Hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance. *Note: Non-standard Exchange plans may: increase the number of covered visits; cover 60 or more*	pp. 32, 33 Form is for both standard and non-standard products and benefit is the same for both.

this substitution or addition differs from the Standard benefit in the space provided.		*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.*	
Non-Standard Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(19)(A)(i) §4303(w) Model Language	This policy or contract form includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 33
Second Surgical Opinion Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(8) 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 33
Mandatory Second Surgical Opinion Model Language Used? Yes ☒ No ☐	4303(b) §4328 Circular Letter No. 29 (1979) Model Language	The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	p. 33
Second Opinion in Other Cases Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 Model Language	This policy or contract form shall include coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 33
Surgical Services	45 CFR § 156.100 §4328	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	

Model Language Used? Yes ☒ No ☐	§3216(l) 11 NYCRR § 52.6 Model Language	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.	pp. 33, 34
Oral Surgery Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 11 NYCRR § 52.16(c)(9) §4328 §3216(l) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 34
Mastectomy Care Model Language Used? Yes ☒ No ☐	§3216(l) §3216(i)(20) §4328 §4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	p. 43
Post Mastectomy Reconstruction Model Language Used? Yes ☒ No ☐	§3216(i)(20) §4328 §4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	p. 34
Transplants	45 CFR § 156.100 §3215(l)	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,	

Model Language Used? Yes ☒ No ☐	§4328 Model Language	and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 34, 35
Autism Spectrum Disorder Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(25) Model Language 11 NYCRR 440	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • behavioral health treatment; • psychiatric care; • psychological care; • medical care provided by a licensed health care provider; • therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • pharmacy care in the event that the policy or contract provides coverage for prescription drugs. This policy or contract form shall include a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy or contract form shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year. The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.	pp. 36-38

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§3216(i)(15-a) §4328 §4303(u) 10NYCRR60-3.1 Model Language	This policy or contract form includes coverage for equipment, supplies and self-management education described in §§ 3216(i)(15-a) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. *Note: For **Standard Products**, the medical benefit cost-sharing must apply. For **Non-Standard** Products, either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.* *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.*	pp. 38-39
Durable Medical Equipment and Braces Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 39, 40
Hearing Aids Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for the standard plan but the limit may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. *{Drafting Note: The limit on hearing aids is required for the standard plan but may be removed or modified so that coverage is more favorable as an option for the non-standard plan.}*	p. 40

		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(o) 45 CFR § 156.100 Model Language	This policy or contract form provides Hospice Care to Member who has been certified by his or her primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. This policy or contract form will also cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. Hospice care will be covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the Hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits. *Note: The Standard Exchange plan must cover 210 days of hospice care. The Non-standard Exchange plan can cover more than 210 days.*	p. 40
Prosthetics Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	External Prosthetic Devices**:** This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for the standard Exchange plan, but may be removed or modified so that coverage is more favorable as an option for the non-standard Exchange Plans.* Internal Prosthetic Devices**:** This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 40, 41

Hospital Services Model Language Used? Yes ☐ No ☐	11NYCRR52.5 45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for inpatient Hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 42
Maternity Care Model Language Used? Yes ☒ No ☐	§3216(i)(10) §4328 4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §3216(i)(10), or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law §6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one breast pump per pregnancy in conjunction with childbirth is covered in full.	pp. 42, 43

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 43
Inpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form includes coverage for Rehabilitation Services including physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime in a Rehabilitation Facility. *Note: The Standard Exchange Plan must cover 60 days. The Non-Standard Exchange Plan may exceed the required 60 days. A Non-standard Exchange plan may also remove the "per condition" and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	p. 43 Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Skilled Nursing Facility	§3216(i)(6)	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility,	

Model Language Used? Yes ☒ No ☐	§4328 §4303(d) 45 CFR § 156.100 Model Language	including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: The Standard Exchange plan must cover 200 days. The Non-standard plan may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 43
End of Life Care Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4805 PHL §4406-e 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live.	p. 44
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes ☒ No ☐	§4328 §4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03(10). Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, individual policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	p. 45
Outpatient Mental Health Care Services Model Language Used? Yes ☐ No ☐	§3216(i)(4) §4328 §4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No.	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Ins. Law §§ 3216(i)(4), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.	p. 45

	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	Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
Inpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient Substance Use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	p. 45
Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to	This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of	p. 46

	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	opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.* *Under MHPAEA, individual policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3216(l) §4328 Model Language	This policy or contract form covers prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a Pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the	pp. 47-55

		same number of prescription drugs in each category and class as the benchmark plan. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Enteral Formulas Model Language Used? Yes ☒ No ☐	§3216(i)(21) §3216(l) §4328 §4303(y) OGC Opinion 10-12-03 Model Language	This policy or contract form provides coverage for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 47
Off-Label Cancer Drug Usage Model Language Used? Yes ☒ No ☐	§3216(i)(12) §4328 §4303(q) Model Language	This policy or contract form may not exclude, or deny, prescription drug coverage because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	pp. 47, 48
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4325(h) PHL §4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	p. 49, para 2, p. 50, para 5
Prohibition for Tier IV Drugs	§4328 §3216(l) §4303(gg) PHL §4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	No Tier IV Drug benefits
Eye Drops Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §4303(hh) Model Language	The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not	p. 48

		limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Orally Administered Anticancer Medications Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(12-a)(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.	pp. 51, 52, para 9
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §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.	p. 51, para 8
Contraceptive Drugs and Devices Model Language Used? Yes ☒ No ☐	§4328 §3216(l) §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. Contraceptive coverage must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law…," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	p. 48
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ☒ No ☐ *Note: Substitution and the addition of benefits to EHB categories are only permissible in Non-Standard Products.* Non-Standard Product? Yes ☒ No ☐ Is this benefit being substituted?	45 CFR § 156.100 §3239 §4328 §3216(l) Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse for certain exercise facility fees or membership fees. If such fees are paid to facilities which maintain equipment and programs that promote cardiovascular wellness and if 50 visits are completed in a 6 month period. The reimbursement is the lesser of $200.00 for the subscriber and $100.00 for the subscriber's spouse or the actual cost of the membership for a 6 month period. *Note: The Non-standard plan may offer more comprehensive coverage or may substitute this benefit.*	p. 56

Yes ☐ No ☒ *Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.* Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.			Form is for both standard and non-standard products and benefit is the same for both.
Non-Standard Benefit explanation:			
Other Wellness Benefits Is this a Standard Exchange Plan? Yes ☒ No ☐ If yes, Additional Wellness Benefits may not be offered.	45 CFR § 156.100 §3239 §4328 §3216(l)	Additional Wellness Benefits may not be covered under a standard Exchange plan but may be covered under a non-standard Exchange plans. All additional wellness benefits must comply with § 3239 of Insurance Law.	
VISION CARE	45 CFR § 156.100		
Pediatric Vision Care Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric vision care including: emergency, preventive and routine vision care for children up to age 19; one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	p. 57
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☒ No ☐ Is dental coverage being	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for children up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; prosthodontics; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance.	pp. 58, 59

provided by this QHP filing? Yes ☐ No ☐			
Explanation:			
ADDITIONAL BENEFITS		**Additional benefits may be covered in the non-standard Exchange plans only.**	
Family Vision Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	
Orthotics Model Language Used? Yes ☐ No ☒	45 CFR § 156.100 §4328 Model Language	This policy or contract form covers orthotic devices that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	
Additional Benefits Provided In Policy or Contract, or By Rider Additional Benefits Provided? Yes ☐ No ☒ If additional benefits are provided, please explain in box below.	11 NYCRR 52.1(c)	The policy or contract form may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	
Explanation:			
Acupuncture		This policy or contract form provides coverage for acupuncture.	Not listed
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	p. 60
Convalescent and Custodial Care	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	

Model Language Used? Yes ☒ No ☐		Necessary.	p. 60
Cosmetic Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(5) 11NYCRR56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	p. 60
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for services are provided to treat an Emergency Condition.	p. 60
Dental Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the Oral Surgery or Pediatric Dental benefits, as applicable.	p. 60
Experimental or Investigational Treatment. Model Language Used? Yes ☒ No ☐	§ 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.	p. 60
Felony Participation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence.	p. 60
Foot Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(6) .Model Language	This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this policy or contract form.	p. 61
Government Facility Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	p. 61
Medically Necessary Model Language Used?	§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	

Yes ☒ No ☐		certified by the State.	p. 61
Medicare or Other Governmental Program Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).	p. 61
Military Service Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	p. 61
No-Fault Automobile Insurance Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	p. 61
Services Separately Billed by Hospital Employees Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	p. 61
Services Provided by a Family Member Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a: child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	p. 61
Services With No Charge Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	p. 61
Services not Listed Model Language Used? Yes ☒ No ☐	§3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	p. 61
Vision Services Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	p. 61
Workers' Compensation	11NYCRR52.16(c)(8)	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.	

Model Language Used? Yes ☒ No ☐	Model Language		pp. 61, 62
War Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	p. 62
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E)	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. 63
Submission of Claim Model Language Used? Yes ☒ No ☐	§3216(d)(1)(G) §4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	p. 63
GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(7) §3217-d(a) §4802 §4324(a)(7) §4306-C(a) PHL §4408(1)(g) PHL § 4408-a 10NYCRR98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in §4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • 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.	pp. 65, 66
Utilization Review Policies and Procedures Model Language Used? Yes ☒ No ☐	§3217-a(a)(3) §4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136	This policy or contract form includes a description of the utilization review policies and procedures, including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration;	pp. 67-70

	Model Language	• the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	
External Appeal Procedures Model Language Used? Yes ☒ No ☐	Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	This policy or contract form includes a description of the external appeal procedures, including: • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal.	pp. 71-74
TERMINATION OF COVERAGE Model Language Used? Yes ☒ No ☐	Model Language §4306(c) §4304(c)	*The following are the only termination provisions permissible under the Insurance Law.* *The model language must be used for each of the following termination provisions.*	Form/Page/Para Reference
Notice of Termination		Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	p. 75, paras 2, 3
Termination for Failure to Pay Premiums	§3216(d)(1)(C) §4304(c)(2)(A) 45 CFR 156.270(g)	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments. Insurers provide a grace period of at least three consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one full month's premium during the benefit year.	p. 75, para 3. a
Reinstatement Following Default	§4306(g)	Contracts subject to Article 43 include a statement that if the individual defaults in making any payment under the contract or policy, the subsequent acceptance of payment by the insurer or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.	
Termination for Fraud	§4304(c)(2)(B) §3216(g)(1)(B) §3105	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	p. 75, para 3. b

Discontinuation of a Class of Coverage	§4304(c)(2)(C) §3216(g)(1)(F)(2)	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each subscriber and beneficiary not less than 90 days for plans subject to Article 32 of the Insurance Law, or 5 months for plans subject to Article 43, prior to the date of discontinuance. The insurer must offer individuals the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those individuals or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	p. 76, para 3. e
Discontinuation of all Policies/Contracts in the Individual Market (Applicable to non-HMOs only)	§4304(c)(2)(C)(ii) §3216(g)(1)(D)	This policy or contract form (other than a HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the individual market upon written notice to the superintendent and to each subscriber, participant, and beneficiary at least 180 days prior to the date of discontinuance.	p. 76, para 3. f
Termination if there are No Longer Insureds in the Insurer's Service Area	§4304(c)(2)(D) §3216(g)(1)(E)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	Provision not included.
Termination for Spouses in cases of divorce	§3216(g)(1)(F)	This policy or contract form provides that in cases of divorce, coverage for the Spouse shall terminate as of the date of the divorce.	p. 75, para 1. b
Termination upon death of Subscriber	§3216(g)(1)(F)	This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	p. 75, para 1. a
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.	p. 75, para 2
Rescission Model Language Used? Yes ☐ No ☒	§3105 §3204 42 USC §300gg-12 45 CFR §147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	No provision for rescission
Renewal	§3216(g) §4304(b)(2) 11 NYCRR 52.17(a)(2)	This policy or contract provides that except as specified in §3216(g), or §4304(b)(2) the insurer must renew or continue in force such coverage at the option of the subscriber. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	p. 82, para 18
Premiums	§4306(a) §3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	Not group coverage
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits	11 NYCRR	This policy or contract form provides that when coverage under this policy or contract form ends,	

Model Language Used? Yes ☒ No ☐	52.17(a)(15) Model Language	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, 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.	p. 77
Suspension of Coverage Model Language Used? Yes ☒ No ☐	§3216(a)(13) §4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC §4317 Model Language	This policy or contract form provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.	p. 79
Conversion - Right to a New Contract After Termination Model Language Used? Yes ☒ No ☐	§4306(i) §3216(c)(5)	This policy or contract form provides that (a) if an individual is no longer covered under a "family policy or contract" because they are no longer within the definition set forth in in the policy or contract form or, (b) a spouse is no longer covered under the policy or contract form because of divorce from the subscriber or annulment of the marriage, or (c) any such policy or contract form is terminated because of the death of the subscriber, then such dependents or spouse, upon application and making of the first payment within 60 days after the date of termination of such policy or contract, shall be offered an individual contract or policy at each level of coverage (i.e, bronze, silver, gold, or platinum) that covers all benefits required by state and federal law. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the "family policy or contract" or whose young adult coverage terminates. Conversion is not available if the issuance of the new policy or contract will result in overinsurance or duplication of benefits according to the standards the issuer has on file with the Superintendent of the New York State Department of Financial Services.	p. 78
GENERAL PROVISIONS			Form/Page/Para Reference
Incontestability Model Language Used? Yes ☒ No ☐	§4306 §3216(d)(1)(B)(1) Model Language	The policy or contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	p. 81, para 10

Changes Model Language Used? Yes ☒ No ☐	§4306(e) §3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	p. 84, para 30
Action in Law or Equity Model Language Used? Yes ☒ No ☐	PHL §4406-a §3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three years following the time such proof of loss is required by the policy or contract.	p. 84, para 26
Subrogation Model Language Used? Yes ☒ No ☐	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	pp. 83, 84, para 25
Unilateral Modification Model Language Used? Yes ☒ No ☐	11 NYCRR52.17 (a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	p. 80, para 3
Non-English Speaking Insureds Model Language Used? Yes ☒ No ☐	PHL §4408(1)(p) §3217-a(a)(15) §4324(a)(15) PHL §4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	p. 84, para 27
SCHEDULE OF BENEFITS Model Language Used? Yes ☒ No ☐	Standard Benefit Design Description Chart 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. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§4328 §4306-e §3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language	The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	No lifetime dollar limits on essential health benefits
Limitations on Annual Dollar Limits Model Language Used? Yes ☒ No ☐	§4328 §3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	No restricted annual dollar limits for essential health benefits

	Model Language		
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.	Yes
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☒ No ☐ If Out-of-Network coverage is offered please answer the following: Out-of-Network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☒	Model Language	If Out-of-Network coverage has been selected, this policy or contract form provides benefits for covered services that are received from Out-of-Network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-Network coverage may be provided in the base policy or contract, or by rider. *Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	EXER-2
Extended Dependent Coverage Model Language Used? Yes ☒ No ☐	§4304(d)(1)(B) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage , this policy or contract form must make available and if requested by the subscriber or policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 3216(a)(4)(C) or 4304(d)(1)(B).	EXER-1
PROVIDER NETWORKS	§3201(c)	The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off-Exchange Plans" will be posted on the Department website and on SERFF.** *Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.*	

		For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3201 11NYCRR52.40(d)(1) 11NYCRR360.10 11NYCRR360.11 §3231(e)(1)(B) §4308(c)(3)(A)	Individual: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Expected claim costs. c. Actuarial justification for claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio %.	
Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: _____ %.	
RATE MANUAL	11NYCRR52.40(c)(2) §3231(e)(1)(B) §4308(c)(3)(A)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

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

		e. Brief description of benefits, types of coverage, limitations, exclusions, issue limits, and renewal conditions. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Outline of marketing rules and methods. i. Underwriting guidelines. j. Expected loss ratio(s).	

Excellus Health Plan, Inc.

This is to certify that the form(s) listed below is/are in compliance with New York State's insurance policy readability law.

1. The form was scored by itself using the Flesch reading ease test and the score meets or exceeds the minimum score of 45*.

2. The form is printed in not less than 10-point type, one point leaded.

3. It is appropriately divided and captioned and presented in a meaningful sequence and each section contains an underlined, boldfaced or otherwise conspicuous title or caption that indicates the nature of the subject matter included in or covered by the section.

4. Where applicable, it contains a table of contents or an index of the principal sections of the form.

5. It has margins that are adequate for purposes of readability.

6. It is printed in such a manner that it includes sufficient contrast of ink and paper to be legible.

7. The form does not use unnecessarily long, complicated or obscure words, sentences or paragraphs.

8. The style, arrangement and overall appearance of the form give no undue prominence to any portion of the form.

Form #	Words	Sentences	Average Characters Per Word	Flesch Score	Medical Terminology Deleted? Yes/No	Defined Words Deleted? Yes/No
EXEC-1*	29,669	1,159	5.2	34.4	No	No
EXEC-2*	28,652	1,129	5.2	34.0	No	No
EXEC-3*	29,453	1,150	5.2	34.1	No	No
EXEC-4*	29,682	1,169	5.2	34.0	No	No
EXER-2*	1,417	56	5.3	33.0	No	No

*Request a waiver pursuant to Insurance Law Section 3102(d)(3)

Excellus Health Plan, Inc.

This is to certify that the form(s) listed below is/are in compliance with New York State's insurance policy readability law.

1. The form was scored by itself using the Flesch reading ease test and the score meets or exceeds the minimum score of 45.

2. The form is printed in not less than 10-point type, one point leaded.

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4. Where applicable, it contains a table of contents or an index of the principal sections of the form.

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6. It is printed in such a manner that it includes sufficient contrast of ink and paper to be legible.

7. The form does not use unnecessarily long, complicated or obscure words, sentences or paragraphs.

8. The style, arrangement and overall appearance of the form give no undue prominence to any portion of the form.

[redacted]

5/16/2013

[redacted]

Date

Senior Deputy General Counsel

Form #	Words	Sentences	Average Characters Per Word	Flesch Score	Medical Terminology Deleted? Yes/No	Defined Words Deleted? Yes/No
EXER-1	254	8	4.8	55.4	No	No

Memorandum of Variable Material for
Form EXEC-1
EXCLUSIVE PROVIDER ORGANIZATION CONTRACT

No.	Page No.	Paragraph Number and/or Name	Variable Field	Explanation
1.	Cover		Logos	Selected by Plan depending upon the d/b/a under which form is issued
2.	Cover		[A nonprofit independent licensee of the BlueCross BlueShield Association]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a
3.	Cover	Footer	[MM]/[DD]/[YYYY] [ ]	Allows Plan to enter effective date of contract. Plan enters assigned alpha-numeric designation for each version of contract in empty bracket, e.g., on versus off-Exchange and "Blue" versus "Univera" versions. The latter will end with a "U".
4.	Cover		[Excellus BlueCross Blue Shield 165 Court Street Rochester, NY 14647; Univera Healthcare 205 Park Club Lane Buffalo, NY 14221]	Selected by Plan depending upon the d/b/a under which the form is issued
5.	Cover		[Signature] [Christopher C. Booth [President and Chief Executive Officer]	Can be updated by Plan if/when the name and/or title of the officer whose signature appears on contract forms changes
6.	1, 2	TOC	Page Numbers	Can be updated by Plan consistent with selection of variable material and resulting page breaks
7.	6	Non-Participating Provider	[or another Blue Cross and/or Blue Shield Plan]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a
8.	6	Participating Provider	[or another Blue Cross and/or Blue Shield Plan] [at: www.excellusbcbs.com; at www.univerahealthcare.com]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued Under Univera d/b/a Selected by Plan depending upon the d/b/a under which form is issued
9.	7	Service Area	[Monroe . . . ; and Jefferson; Allegany . . . ; and Wyoming]	Plan selects counties up to "and Jefferson" when form is issued under "Blue" d/b/a and remaining

				eight counties when form is issued under "Univera" d/b/a
10.	9	3. Participating Providers	[at www.excellusbcbs.com; at www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
11.	11	OUR WEBSITE	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
12.	14	1. Deductible	[Deductible . . . Plan Year.] [Deductible . . . Plan Year.]	Plan selects first option for all plans with a deductible other than non-standard Silver and Bronze HDHP plans as described below Plan selects second option for non-standard Silver and Bronze HSA-eligible plans Plan deletes both paragraphs for plans that do not have a deductible
13.	14.	2. Copayments	[after you have satisfied the annual Deductible as described above,]	Selected by Plan for options that have a deductible and deleted in its entirety for those that do not
14.	14	4. Out-of-Pocket Limit	[If you have other . . . person.]	Plan selects as applicable for plans under which members can meet OOP limit on an individual basis
15.	15	5. Allowed Amount	[, or the amount approved by another BlueCross and/or BlueShield plan]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when form is issued under "Univera" d/b/a
16.	16	Children Covered under this Certificate	[month; year] [26]	Plan typically selects "month", but wishes to retain option to select "year" Plan uses 26 unless make-available option to extend coverage to age 30 is selected
17.	17	Open Enrollment	[You can . . . by then.] [the Exchange receives] [We receive] [the Exchange; Us] [the Exchange; Us] [the Exchange receives] [We receive]	Plan selects as appropriate pursuant to DFS Drafting Note Plan selects as appropriate for on versus off-Exchange plans
18.	17, 18, 19	Special Enrollment Periods	[Outside . . . reductions.] [Outside . . . coverage.] [We; The Exchange] [We must receive any] [We; the Exchange]	Plan selects first option for on-Exchange plans and the second option for off-Exchange plans Plan selects as appropriate for off versus on-Exchange plans

			receive[s] [We; the Exchange] receive[s] [Otherwise coverage begins on the date on which the Exchange receives notice as long as Your applicable Premium payment is received by then; Otherwise coverage begins on the date on which We receive notice and the Premium payment] [Advance Payments . . . month.] [the Exchange; We] receives[s] [qualified health plan]	Plan selects first option for on-Exchange and second for off-Exchange Plan selects for on-Exchange only and deletes in its entirety for off-Exchange Plan selects as appropriate for on versus off-Exchange plans Plan selects for on-Exchange only and deletes in its entirety for off-Exchange
19.	21, 22	Preventive Care, B. Adult Annual Physical Examinations, D. Well-Woman Examinations	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
20.	32	Maternity and Newborn Care	renting [or the purchase of] one breast pump	Plan can select bracketed language for non-standard and off-Exchange plans
21.	48, 49, 51, 52, 55	Covered Outpatient Prescription Drugs, 3. Participating Pharmacies, 5. Mail Order, 6. Tier Status, 8. Supply Limits, 1. Preauthorization Formulary	[www.excellusbcbs.com; www.univerhealthcare.com] or [at www.excellusbcbs.com; at www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
22.	48	1. Cost-Sharing Expenses	[An additional charge may apply when a Prescription Drug on a higher tier… The cost difference must be paid in addition to the lower tier Copayment or Coinsurance.]	Plan selects for non-standard plans and deletes in its entirety for standard plans
23.	49, 50	4. Designated	[Acromegaly . . .Vasoactive	Allows Plan to submit revised list of

		Pharmacies	intestinal peptide tumors]	drug classes included in the Designated Pharmacy program
24.	58, 59	[Section VI Pediatric Dental Care	[Section VI Pediatric Dental Care . . . of retainers).]	Allows Plan to delete Pediatric Dental Care benefit in its entirety if stand-alone product is available on the Exchange
25.	60	Dental Services	[or pediatric dental care]	Plan deletes when Pediatric Dental Care benefit is deleted
26.	63	Notice of Claim	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
27.	67	Utilization Review	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
28.	75	1. c	[26] years of age	Plan uses 26 unless make-available option to extend coverage to age 30 is selected
29.	75	2.	[Us, the Exchange]	Plan selects as appropriate for off versus on-Exchange plans
30.	75	3. a	[do not receive advance payments . . . and] [If You receive advance payments . . . terminates.]	Plan selects for on-Exchange plans and deletes in entirety for off-Exchange plans
31.	75	3. b	[Us; the Exchange]	Plan selects as appropriate for off versus on-Exchange plans
32.	82	14. Notice	[165 Court Street, Rochester, NY 14647; 205 Park Club Lane, Buffalo, NY 14221]	Selected by Plan depending upon the d/b/a under which form is issued: Rochester for “Blue” and Buffalo for “Univera”
33.	83	22. [Service Marks	[Service Marks . . . agreement.]	Selected by Plan when form is issued under “Blue” d/b/a and deleted in its entirety when issued under “Univera” d/b/a

[4811-1161-7299, v. 3]

Memorandum of Variable Material for
Form EXEC-2
EXCLUSIVE PROVIDER ORGANIZATION CONTRACT

No.	Page No.	Paragraph Number and/or Name	Variable Field	Explanation
1.	Cover		Logos	Selected by Plan depending upon the d/b/a under which form is issued
2.	Cover		[A nonprofit independent licensee of the BlueCross BlueShield Association]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a
3.	Cover	Footer	[MM]/[DD]/[YYYY] [ ]	Allows Plan to enter effective date of contract. Plan enters assigned alpha-numeric designation for each version of contractin empty bracket, e.g., on versus off-Exchange and "Blue" versus "Univera" versions. The latter will end with a "U".
4.	Cover		[Excellus BlueCross Blue Shield 165 Court Street Rochester, NY 14647; Univera Healthcare 205 Park Club Lane Buffalo, NY 14221]	Selected by Plan depending upon the d/b/a under which the form is issued
5.	Cover		[Signature] [Christopher C. Booth [President and Chief Executive Officer]	Can be updated by Plan if/when the name and/or title of the officer whose signature appears on contract forms changes
6.	1, 2	TOC	Page Numbers	Can be updated by Plan consistent with selection of variable material and resulting page breaks
7.	6	Non-Participating Provider	[or another Blue Cross and/or Blue Shield Plan]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a
8.	6	Participating Provider	[or another Blue Cross and/or Blue Shield Plan] [at www.excellusbcbs.com; at www.univerahealthcare.com]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued Under Univera d/b/a Selected by Plan depending upon the d/b/a under which form is issued
9.	7	Service Area	[Monroe . . . ; and Jefferson; Allegany . . . ; and Wyoming]	Plan selects counties up to "and Jefferson" when form is issued under "Blue" d/b/a and remaining

				eight counties when form is issued under "Univera" d/b/a
10.	9	3. Participating Providers	[at www.excellusbcbs.com; at www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
11.	11	OUR WEBSITE	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
12.	14	1. Deductible 2. Copayments	[Except where stated otherwise, . . . for that Plan Year.] after you have satisfied the annual Deductible as described above,]	Selected by Plan for options that have a deductible and deleted in their entirety for those that do not
13.	14	4. Out-of-Pocket Limit	[If you have other . . . person.]	Plan selects as applicable when members can meet OOP limit on an individual basis
14.	14	5. Allowed Amount	[, or the amount approved by another BlueCross and/or BlueShield plan]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when form is issued under "Univera" d/b/a
15.	16	Open Enrollment	[You can . . . by then.] [the Exchange receives] [If we receive] [the Exchange; Us] [the Exchange; Us]	Plan selects as appropriate pursuant to DFS Drafting Note Plan selects as appropriate for on versus off-Exchange plans
16.	17, 18	Special Enrollment Periods	[Outside . . . reductions.] [Outside . . . coverage.] [We; The Exchange] [We; the Exchange] receive[s] [We; the Exchange] receives[s] [Otherwise coverage begins on the date on which the Exchange receives notice as long as Your applicable Premium payment is received by then; Otherwise coverage begins on the date on which We receive notice and the Premium payment] [Advance payments . . . month.]	Plan selects first option for on-Exchange plans and the second option for off-Exchange plans Plan selects as appropriate for off versus on-Exchange plans Plan selects first option for on-Exchange and second option for off-Exchange Plan selects for on-Exchange only and deletes in entirety for off-

			[the Exchange; We] receives[s] . . . [qualified health plan]	Exchange Plan selects as appropriate for on versus off-Exchange plans Plan selects for on-Exchange only and deletes in its entirety for off-Exchange
17.	19, 20	Preventive Care, B. Adult Annual Physical Examinations, D. Well-Woman Examinations	[www.excellusbcbscom; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
18.	46, 47, 49, 50, 53	Covered Outpatient Prescription Drugs, 2. Participating Pharmacies, 5. Mail Order, 6. Tier Status, 8. Supply Limits, 1. Preauthorization Formulary	[www.excellusbcbs.com; www.univerhealthcare.com] or [at www.excellusbcbs.com; at www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
19.	46	1. Cost-sharing Expenses	[An additional charge may apply when a Prescription Drug on a higher tier… The cost difference must be paid in addition to the lower tier Copayment or Coinsurance.]	Plan selects for non-standard plans and deletes in its entirety for standard plans
20.	47, 48	4. Designated Pharmacies	[Acromegaly . . .Vasoactive intestinal peptide tumors]	Allows Plan to submit revised list of drug classes included in the Designated Pharmacy program
21.	56, 57	[Section VI Pediatric Dental Care	[Section VI Pediatric Dental Care . . . of retainers).]	Allows Plan to delete Pediatric Dental Care benefit in its entirety if stand-alone product is available on the Exchange
22.	58	Dental Services	[or pediatric dental care]	Plan deleted when Pediatric Dental Care benefit is deleted
23.	61	Notice of Claim	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon d/b/a under which form is issued
24.	65	Utilization Review	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
25.	73	2, 3. b	[Us, the Exchange] [Us; the Exchange]	Plan selects as appropriate for off and on-Exchange plans
26.	73	3. a	[do not receive . . . and] [If you . . . coverage terminates.]	Plan selects for on-Exchange plans and deletes in entirety for off-Exchange plans
27.	74	3. d and e	[You; the Responsible Adult]	Plan selects as appropriate

				depending upon who receives the notice of termination
28.	81	14. Notice	[165 Court Street, Rochester, NY 14647; 205 Park Club Lane, Buffalo, NY 14221]	Selected by Plan depending upon the d/b/a under which form is issued: Rochester for "Blue" and Buffalo for "Univera"
29.	81	22. [Service Marks	[Service Marks . . . agreement.]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a

[4818-8369-6915, v. 3]

Memorandum of Variable Material for
Form EXEC-3
EXCLUSIVE PROVIDER ORGANIZATION CONTRACT

No.	Page No.	Paragraph Number and/or Name	Variable Field	Explanation
1.	Cover		Logos	Selected by Plan depending upon the d/b/a under which form is issued
2.	Cover		[A nonprofit independent licensee of the BlueCross BlueShield Association]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a
3.	Cover	Footer	[MM]/[DD]/[YYYY] [ ]	Allows Plan to enter effective date of contract. Plan enters assigned alpha-numeric designation for each version of contract in empty bracket, e.g., "Blue" versus "Univera" versions. The latter will end with a "U".
4.	Cover		[Excellus BlueCross Blue Shield 165 Court Street Rochester, NY 14647; Univera Healthcare 205 Park Club Lane Buffalo, NY 14221]	Selected by Plan depending upon the d/b/a under which the form is issued
5.	Cover		[Signature] [Christopher C. Booth [President and Chief Executive Officer]	Can be updated by Plan if/when the name and/or title of the officer whose signature appears on contract forms changes
6.	1, 2	TOC	Page Numbers	Can be updated by Plan consistent with selection of variable material and resulting page breaks
7.	6	Non-Participating Provider	[or another Blue Cross and/or Blue Shield Plan]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a
8.	6	Participating Provider	[or another Blue Cross and/or Blue Shield Plan] [at: www.excellusbcbs.com; at www.univerahealthcare.com]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued Under Univera d/b/a Selected by Plan depending upon the d/b/a under which form is issued
9.	7	Service Area	[Monroe . . . ; and Jefferson; Allegany . . . ; and Wyoming]	Plan selects counties up to "and Jefferson" when form is issued under "Blue" d/b/a and remaining

				eight counties when form is issued under "Univera" d/b/a
10.	9	3. Participating Providers	[at www.excellusbcbs.com; at www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
11.	11	OUR WEBSITE	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
12.	15	6. Allowed Amount	[, or the amount approved by another BlueCross and/or BlueShield plan]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when form is issued under "Univera" d/b/a
13.	16	Children Covered under this Certificate	[month; year] [26]	Plan typically selects "month", but wishes to retain option to select "year" Plan uses 26 unless make-available option to extend coverage to age 30 is selected
14.	17	Open Enrollment	[You can enroll . . . by then.]	Plan selects for initial enrollment period and deletes when the period has expired
15.	18	Special Enrollment Periods	[We receive; the Exchange receives] [We receive; the Exchange receives] [Otherwise coverage begins on the date on which the Exchange receives notice as long as Your applicable Premium payment is received by then; Otherwise coverage begins on the date on which We receive notice and the Premium payment]	Plan selects as appropriate for on versus off-Exchange Plan selects first option for on-Exchange and second option for off-Exchange
16.	21, 22	Preventive Care, B. Adult Annual Physical Examinations, D. Well-Woman Examinations	[www.excellus BCBS.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
17.	48, 49, 51, 52, 55	Covered Outpatient Prescription Drugs, 3. Participating Pharmacies, 5. Mail Order, 6. Tier Status, 8. Supply Limits,	[www.excellusbcbs.com; www.univerhealthcare.com] or [at www.excellusbcbs.com; at www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued

		1. Preauthorization Formulary		
18.	49, 50	4. Designated Pharmacies	[Acromegaly . . .Vasoactive intestinal peptide tumors]	Allows Plan to submit revised list of drug classes included in the Designated Pharmacy program
19.	58, 59	[Section VI Pediatric Dental Care	[Section VI Pediatric Dental Care . . . of retainers).]	Allows Plan to delete Pediatric Dental Care benefit in its entirety if stand-alone product is available on the Exchange
20.	60	Dental Services	[or pediatric dental care]	Plan deletes when Pediatric Dental Care benefit is deleted
21.	63	Notice of Claim	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
22.	67	Utilization Review	[www.excellusbcbs.com; www.univerahealthcare.com]	Selected by Plan depending upon the d/b/a under which form is issued
23.	75	1. c	[26] years of age	Plan uses 26 unless make-available option to extend coverage to age 30 is selected
24.	82	14. Notice	[165 Court Street, Rochester, NY 14647; 205 Park Club Lane, Buffalo, NY 14221]	Selected by Plan depending upon the d/b/a under which form is issued: Rochester for “Blue” and Buffalo for “Univera”
25.	83	22. [Service Marks	[Service Marks . . . agreement.]	Selected by Plan when form is issued under “Blue” d/b/a and deleted in its entirety when issued under “Univera” d/b/a

[4820-1522-8179, v. 3]

Memorandum of Variable Material for
Form EXEC-4
EXCLUSIVE PROVIDER ORGANIZATION CONTRACT

No.	Page No.	Paragraph Number and/or Name	Variable Field	Explanation
1.	Cover		Logo	Can be updated by Plan if "Blue" logo changes
2.	Cover	Footer	[MM]/[DD]/[YYYY] [ ]	Allows Plan to enter effective date of contract. Plan enters assigned alpha-numeric designation for each version of contract in empty bracket, e.g., on versus off-Exchange
3.	Cover		[Excellus BlueCross Blue Shield; 165 Court Street Rochester, NY 14647]	Can be updated by Plan if "Blue" address changes
4.	Cover		[Signature] [Christopher C. Booth [President and Chief Executive Officer]	Can be updated by Plan if/when the name and/or title of the officer whose signature appears on contract forms changes
5.	1, 2	TOC	Page Numbers	Can be updated by Plan consistent with selection of variable material and resulting page breaks
6.	7	Service Area	[Otsego, Herkimer and Delaware]	Can be updated Plan if counties in Bassett Preferred network change
7.	16	Children Covered under this Certificate	[month; year] [26]	Plan typically selects "month", but wishes to retain option to select "year" Plan uses 26 unless make-available option to extend coverage to age 30 is selected
8.	17	Open Enrollment	[You can . . . by then.] [the Exchange receives] [We receive] [[the Exchange; Us] [the Exchange; Us] [the Exchange receives] [We receive]	Plan selects as appropriate pursuant to DFS Drafting Note Plan selects as appropriate for on versus off-Exchange plans
9.	17, 18, 19	Special Enrollment Periods	[Outside . . . reductions.] [Outside . . . coverage.] [We; The Exchange] [We must receive any] [We; the Exchange] receive[s]	Plan selects first option for on-Exchange plans and the second option for off-Exchange plans Plan selects as appropriate for off versus on-Exchange plans

			[We; the Exchange] receive[s] [Otherwise coverage begins on the date on which the Exchange receives notice as long as Your applicable Premium payment is received by then; Otherwise coverage begins on the date on which We receive notice and the Premium payment] [Advance Payments . . . month.] [the Exchange; We] receives[s] [qualified health plan]	Plan selects first option for on-Exchange and second option for off-Exchange Plan selects for on-Exchange only and deletes in entirety for off-Exchange Plan selects as appropriate for on versus off-Exchange plans Plan selects for on-Exchange only and deletes in its entirety for off-Exchange
10.	49, 50	4. Designated Pharmacies	[Acromegaly . . .Vasoactive intestinal peptide tumors]	Allows Plan to submit revised list of drug classes included in the Designated Pharmacy program
111.	58, 59	[Section VI Pediatric Dental Care	[Section VI Pediatric Dental Care . . . of retainers).]	Allows Plan to delete Pediatric Dental Care benefit in its entirety if stand-alone product is available on the Exchange
12.	60	Dental Services	[or pediatric dental care]	Plan deletes when Pediatric Dental Care benefit is deleted
13.	75	1. c	[26] years of age	Plan uses 26 unless make-available option to extend coverage to age 30 is selected
14.	75	2.	[Us, the Exchange]	Plan selects as appropriate for off versus on-Exchange plans
15.	75	3. a	[do not receive advance payments . . . and] [If You receive advance payments . . . terminates.]	Plan selects for on-Exchange plans and deletes in entirety for off-Exchange plans
16.	75	3. b	[Us; the Exchange]	Plan selects as appropriate for off versus on-Exchange plans

[4846-1405-8771, v. 4]

Memorandum of Variable Material for
Form EXER-1
RIDER TO EXTEND COVERAGE FOR YOUNG ADULTS THROUGH AGE 29

No.	Page No.	Paragraph Number and/or Name	Variable Field	Explanation
1.	1		Logos	Selected by Plan depending upon the d/b/a under which form is issued
2.	1		[A nonprofit independent licensee of the BlueCross BlueShield Association]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a
3.	1	Introductory	[Subscriber; Group] [Contract; Certificate] [Contract; Certificate]	Plan selects "Subscriber" for individual plans and "Group" for group plans Plan selects "Contract" for individual plans and "Certificate" for group plans
4.	1	Footer	[MM]/[DD]/[YYYY] [ ]	Allows Plan to enter effective date of rider. Plan enters assigned alpha-numeric designation for each version of form in empty bracket, e.g., on versus off-Exchange and "Blue" versus "Univera" versions. The latter will end with a "U".
5.	1, 2		[Excellus BlueCross Blue Shield 165 Court Street Rochester, NY 14647; Univera Healthcare 205 Park Club Lane Buffalo, NY 14221; Upstate HMO 165 Court Street Rochester, NY 14647; Univera Healthcare HMO 205 Park Club Lane Buffalo, NY 14221]	Selected by Plan depending upon the d/b/a under which the form is issued. Plan selects from first two options when form attaches to EPO Contract or PPO certificate and from second two options when form attaches to HMO certificate.
6.	2		[Signature] [Christopher C. Booth [President and Chief Executive Officer]	Can be updated by Plan if/when the name and/or title of the officer whose signature appears on contract forms changes

[4825-1055-3875, v. 3]

Memorandum of Variable Material for
Form EXER-2
Out-of-Network Benefits Rider

No.	Page No.	Paragraph Number and/or Name	Variable Field	Explanation
1.	1		Logos	Selected by Plan depending upon the d/b/a under which form is issued
2.	1		[A nonprofit independent licensee of the BlueCross BlueShield Association]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a
3.	1	Footer	[MM]/[DD]/[YYYY] [ ]	Allows Plan to enter effective date of rider. Plan enters assigned alpha-numeric designation for each version of form in empty bracket, e.g., "Blue" versus "Univera" versions. The latter will end with a "U".
4.	3	6. Allowed Amount	For Facilities in Our Service Area, the Allowed Amount will be [80]% of the Centers for Medicare and Medicaid Services Prospective Payment System (PPS) amount unadjusted for geographic locality. If there is no amount as described above, the Allowed Amount will be [75]% of the Facility's charge. For Facilities outside Our Service Area, the Allowed Amount will be [150]% of the Centers for Medicare and Medicaid Services Prospective Payment System (PPS) amount unadjusted for geographic locality. If there is no amount as described above, the Allowed Amount will be [75]% of the Facility's charge.	The percentage values are bracketed to allow the Plan to submit additional percentage variables for approval in the future by submitting a new MOVM to be placed on file. The Plan does not intend to offer alternative values at this time.

			For all other Providers in Our Service Area, the Allowed Amount will be [80]% of the Centers for Medicare and Medicaid Services Prospective Payment System amount unadjusted for geographic locality. If there is no amount as described above, the Allowed Amount will be [75]% of the Provider's charge. For all other Providers outside Our Service Area, the Allowed Amount will be [150]% of the Centers for Medicare and Medicaid Services Prospective Payment System amount unadjusted for geographic locality. If there is no amount as described above, the Allowed Amount will be [75]% of the Provider's charge.	
5.	4	6. Allowed Amount	[or to pay a BlueCross and/or BlueShield Host Plans' rate, if lower]	Selected by Plan when form is issued under "Blue" d/b/a and deleted in its entirety when issued under "Univera" d/b/a
6.	5		[Excellus BlueCross Blue Shield 165 Court Street Rochester, NY 14647; Univera Healthcare 205 Park Club Lane Buffalo, NY 14221]	Selected by Plan depending upon the d/b/a under which the form is issued
7.	5		[Signature] [Christopher C. Booth [President and Chief Executive Officer]	Can be updated by Plan if/when the name and/or title of the officer whose signature appears on contract forms changes

Memorandum of Variable Material for
Form EXER-2
Out-of-Network Benefits Rider

[4823-9422-6963, v. 2]

Memorandum of Variable Material for
Forms EXES-1—EXES-13, EXES-26—EXES-41
SCHEDULE OF BENEFITS

No.	Variable Material	Explanation
1.	[[[XXX] Plan Marketing Name] [Metal Level] [Standard; Select; Base]] Schedule of Benefits [Catastrophic Level]	XXX allows the Plan to enter the ID# for each separate plan Brackets around Plan Marketing Name allow the Plan to enter current marketing names: Excellus BCBS or Univera for individual plans, or add new plan marketing names at a later date by submitting an updated MOVM. Plan adds appropriate Metal Level for each Plan. Plan adds "Standard" or "Select" after the Metal Level for standard and non-standard individual plans, respectively. The Plan selects "Base" and "Catastrophic Level" for the on-Exchange only catastrophic plan. In addition to the Schedule of Benefits for the catastrophic plan, EXES-9, the following Schedules of Benefits will attach to plans that will only be offered on the Exchange: EXES-5, EXES-6, EXES-7 (Silver CSR); EXES-8 (Indian Zero Cost Sharing); EXES-26 (Bassett Indian Zero Cost Sharing); EXES-38, EXES-39, EXES-40 (Child Only Silver CSR); and EXES-41 (Child Only Indian Zero Cost Sharing).
2.	[MM]/[DD]/[YYYY] [ ]	Allows the Plan to enter effective date of the Schedule of Benefits. Plan enters assigned alpha-numeric designation for each version of form in empty bracket, e.g., on versus off-Exchange, and "Blue" versus "Univera" versus. The latter will end with a "U".
3.	[Dental &]	Allows the Plan to delete from the Pediatric Dental & Vision Care benefits section of the Schedules of Benefits when the Pediatric Dental Care benefit is deleted as described in #4 below

4.	[Pediatric Dental Care]	This benefit is bracketed throughout, allowing the Plan to delete the benefit in its entirety if stand-alone dental coverage is available on the Exchange, or for off-Exchange plans has been obtained from a certified stand-alone dental plan offered outside the Exchange

[4830-1819-5475, v. 3]

Excellus Health Plan, Inc.

2014 Community Rate Submission
Individual

Actuarial Memorandum

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Appendix

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Actuarial Memorandum

Purpose

The purpose of this rate filing is to present for approval premium rates to be offered by Excellus Health Plan ("EHP") on the individual market with effective dates beginning January 1, 2014 through December 31, 2014. Rates have been developed in compliance with Federal ACA requirements as well as New York statute and regulation for non-grandfathered community-rated products. This filing may not be appropriate for other purposes.

EHP is following the procedure outlined in New York State's Department of Financial Services' ("DFS") "Instructions for the Submission of 2014 Premium Rates for Individual On-Exchange Plans and Off- Exchange Plans" ("Individual Instructions").

The SERFF number of the associated QHP template filing is EXHP-128987637.

Development of Rates Overview

In general, rate development for all products is outlined as follows:

- Calculate the total projected index rate including the following components:
  - Actuarial value ("AV") adjusted experience period index rate
  - Market-wide adjustments to the AV adjusted experience period index rate such as:
    - Impact of adjusting experience period data to essential health benefit ("EHB") level
    - Ratio of individual risk pool to small group risk pool
    - Impact of Federal Risk Adjustment Program
    - Impact of Federal Transitional Reinsurance Program
    - Claim trend projection factor
  - Plan Level Adjustments such as:
    - Pricing AV
    - Impact of Provider Network Characteristics
    - Benefits in addition to EHB
    - Administrative Costs
    - Contribution to Surplus
    - Addition of Out of Network Benefits
    - Stop Loss on Healthy New York
- Calculate the all regions combined premium rates
- Calculate the premium rates for each applicable rating region
- Calculate the final premium rates
- Calculate premium rates for subsequent quarters

These steps are described in further detail below.

Calculation of the Index Rate

AV Adjusted Experience Period Index Rate

The framework relies on small group data from the experience period that is incurred from 10/1/2011 through 9/30/2012, paid from 10/1/2011 through 12/31/2012 and completed to ultimate. The claims data excludes adjustments for the Regulation 146 risk adjustment pool, adjustments for the current Stop Loss Reimbursement pool, and the experience of discontinued small group products. The experience of small group grandfathered plans is included in the data.

The AV adjusted experience period index rate is equal to the incurred claims PMPM adjusted for the average pricing AV in the experience period. The average pricing AV is weighted using experience period member months. Exhibit 8 shows the AV adjusted experience period index rate in line 12.

Market Wide Adjustments

Market wide adjustments are those impacts that do not vary by plan option. Adjustments are applied uniformly.

Impact of adjusting experience period data to EHB level

The AV adjusted experience period index rate requires adjustments in order to align with the EHB benefit level:

- Incurred claims for adult vision benefits and the healthy rewards program are removed.
- Women's preventive benefits and the autism mandate became effective on 1/1/2013 which is after the experience period and therefore require claim estimates to be added in.
- Estimated incurred claims for the EHB gym benefit are added in.
- Prescription drug incurred claims within the experience period are based on an open formulary and have been converted to a closed formulary basis.

The overall impact of adjusting the experience period data to EHB benefit level is shown in Exhibit 8 in line 13.

Ratio of Individual Risk Pool to Small Group Risk Pool

The individual risk pool relative to the small group risk pool factor is based on the assumed morbidity and demographic differences between the two pools. Two approaches are considered in determining the relative difference in average morbidity and demographics.

The first approach compares the weighted average risk scores between the current small group pool and the projected individual pool where the projected individual pool is made up of a mix of enrollment from existing lines of business and new business. The

risk scores are determined by EHP's predictive modeling vendor and include the impacts of morbidity and demographics.

The second approach is based on an analysis performed by an external consultant. The consultant developed an estimate of the relative morbidity between the small group market and the projected individual market before consideration of any demographic differences. These demographic differences are separately accounted for using the weighted average demographic factor for the projected individual pool. The relative morbidity and the relative demographic differences are combined for each pool resulting in a second individual to small group ratio estimate.

The selected individual to small group ratio based on these two approaches is represented by line 18 in Exhibit 8.

Impact of Federal Risk Adjustment Program

DFS performed a simulation study with Deloitte consulting company to project the impact of the Federal Risk Adjustment Program to each carrier. The study relied on data from all carriers within the state of New York and was carried out in a short time frame.

EHP is concerned with an approach that is not fully controlled, does not address the new populations that will be entering the pool, and does not consider the relative impacts between companies from future risk adjustment activities and initiatives. Given this as well as other significant changes related to health care reform in 2014, the results of the study based solely on a prior experience period are not indicative of future risk adjustment results. Due to the uncertainty surrounding the simulation project and make-up of the future risk pools, EHP is applying $0.00 per member per month ("PMPM") as the impact of the risk adjustment program. This amount is reflected in Exhibit 8 in line 20.

Impact of Federal Transitional Reinsurance Program

Within the DFS simulation study related to risk adjustment, the potential impacts of the transitional reinsurance program were also analyzed. Given the significant changes related to health care reform expected in the individual market in 2014, the composition of the individual market will likely differ significantly from the experience used in the simulation. In order to estimate the reinsurance recovery, EHP is using the DFS PMPM estimates for the individual and small group markets along with the projected composition of the 2014 individual pool and the associated risk scores calculated by EHP's predictive modeling vendor. For those members expected to remain in the individual pool, the individual pool estimated PMPM is used as a basis whereas the small group estimated PMPM is the basis used for all other members, including those that are currently uninsured.

EHP calculates an expected average reinsurance recovery of $31.12 on a PMPM basis.

The figure above represents the 2014 PMPM impact to 2014 premium rates. The reinsurance recovery PMPM that is used in the rate development process is trended from the experience period to the rating period and adjusted for the pricing AV of each plan. In order for the 2014 rates to be adjusted appropriately, the reinsurance recovery PMPMs must be adjusted as follows:

$31.12 / claim trend factor / average pricing AV = $31.12 / 1.18 / .694 = $37.93

Exhibit 8 shows the adjusted figure as a factor in line 21.

Claim Trend Projection Factor

Annual claim trends are determined based on expected cost and utilization by claim type, as well as the effect of deductible leveraging, drug rebate credits, and non-system claims' trends. Also included in the annual trend is an adjustment between the experience and rating periods to account for a change in EHP's pharmacy benefits manager contract and the impact of removing pre-existing condition exclusions for adults. The resulting net annual trend is 7.7%. The claim trend projection factor is calculated by raising the annual trend factor to an exponent determined by months of trend divided by 12. Months of trend is based on the number of months necessary to properly trend the experience period claims to the applicable rating period. In this case, 27 months of trend is applied to project the experience from the experience period to the rating period.

Exhibit 8 shows the claims trend projection factor in line 23.

Plan Level Adjustments

Plan level adjustments vary by plan option. These impacts are applied in addition to the market wide adjustments.

Pricing Actuarial Value

The pricing actuarial values are based on the Milliman Managed Care Rating Model ("MCRM"). This model allows for the comparison of the expected claim costs for each benefit package on a per member per month basis. There is no impact related to variation in demographics, selection, or regional provider contracting among plan options.

The pricing AV is calculated as the expected claim cost of the plan option from the MCRM relative to that of a plan that covers all benefits with no cost sharing. The impacts of benefits in addition to EHB and adding out of network benefits are not reflected in the pricing AV. These are discussed further in later sections.

The calculated pricing AV for each plan is shown in line 28 of Exhibit 8.

Impact of Provider Network Characteristics

The Bassett Gold Select plan (HIOS ID 78124NY092) is a non-standard two-tiered network design. The two tiers within the plan are the Bassett Healthcare Network and the standard commercial in network. The weighted average network adjustment relative to the commercial population is .831 for this custom plan.

Exhibit 8 shows the provider network adjustments for each plan in line 30.

Benefits in Addition to EHB

There are no covered benefits in addition to EHB in the individual market.

Administrative Costs

Administrative cost components are applied to premium using the fixed cost method and percentage of premium method, as appropriate. The fixed cost method applies the same PMPM to each plan option while the percentage of premium method applies an amount to each plan option in relation to the premium. The following components of administrative costs are applied as a fixed cost: operating expenses, quality improvement, reinsurance fee, risk adjustment fee, and the patient-centered outcomes research institute fee. The administrative cost components that are applied as a percentage of premium amounts are as follows: health insurance provider fee, broker commissions, and section 206 (formerly section 332) assessment.

Exhibit 8 shows the administrative cost impacts for each plan option in line 34.

Contribution to Surplus

The rates include a contribution to surplus component of 2% of premium for all plan options. Line 35 of Exhibit 8 shows the contribution to surplus for each plan option.

Addition of Out of Network Benefits

EHP has an extensive provider network within each service region. The addition of out of network benefits is a small impact to premium rates. Out of network benefits are only included in the DFS standard platinum option. Exhibit 8 shows the impact for each applicable plan option in line 37.

Stop Loss on Healthy New York

Healthy New York is not a plan option in the individual market.

Preliminary PMPM Premium Rates

The preliminary PMPM premium rates for each plan are based on the combined impact of the market wide adjustments and the plan level adjustments to the AV adjusted experience period index rate.

The preliminary PMPM premium rates are shown in line 42 of Exhibit 8.

Calculation of all Regions Combined Premium Rates

The all regions combined premium rates are calculated by applying the conversion factor and the standardized census tier factor adjustments to the preliminary PMPM premium rates (Exhibit 8, line 42). The conversion factor and standardized census tier factors are discussed in more detail below.

Conversion Factor

The conversion factor is the adjustment factor that is applied to the PMPM premium rate to calculate the single premium rate. The calculation of the conversion factor is based on December 2012 members and subscribers split into the standard four tier rating structure. The conversion factor is then calculated as the average members per contract divided by the average standardized census tier factor weighted by contract type distribution. The calculated conversion factor is 1.2008.

Census Tier Factors

DFS has required the use of the following census tiers and relativities:

Contract Type	Tier Factor
Single	1.00
Single and Spouse	2.00
Single and Child(ren)	1.70
Single, Spouse and Child(ren)	2.85

For child only plans, DFS has required that the premium rate be set at 41.2% of the corresponding single rate.

<u>Calculation of Premium Rates by Applicable Rating Region</u>

The premium rates for each applicable rating region are determined by adjusting the all regions combined premium rates by each applicable area factor. The calculation of the area factors are discussed further below.

Area Factors

The area factors are calculated based on insured commercial experience incurred and paid in 2012. The provider reimbursements and distribution of services are split by region. The resulting area factor is the ratio of the applicable area's total allowed claims divided by the services of the applicable region relative to the total allowed claims of all regions divided by the services of all regions combined. These area adjustments represent the relative difference in the claim costs of each region.

In the process for developing regional premium rates prescribed by the DFS, the area adjustment is applied to the all regions' premium rates instead of only the claims cost components. Due to this, an additional adjustment to the area factors is required to account for the portion of the premium that is represented by fixed PMPM administrative costs which do not vary by region.

The area factors that are applied in the rate development are:

Region	Premium Area Factor (Applied)
Rochester	0.9088
Syracuse	1.0403
Utica/Watertown	1.1073
Buffalo	1.0759
Mid-Hudson	1.1073
Albany	1.1073

Calculation of Final Premium Rates

The premium rates are further adjusted for the additional coverage of the following: pediatric dental, oral contraceptives covered in full, dependents through age 29, and domestic partner. These are discussed in detail below.

Pediatric Dental

The pediatric dental premium rates are calculated using the projected 2014 expected utilization per 1,000 members split by dental service along with the 2014 fee schedules for each service. Two different fee schedules are used to represent 2014 allowed costs per service: Blue Shield and Univera. The Blue Shield fee schedule is used to calculate the rates of all regions except for Buffalo. The Univera fee schedule is used to calculate the rates in the Buffalo region. The claims cost PMPM of each plan is calculated based on the average utilization of services per member.

The premium rates for each product are then calculated by applying the following to the claims cost PMPMs: ratio of the individual risk pool relative to small group risk pool, portion of administrative expenses that are based on a percentage of premium, conversion factor, and standardized census tier factors. The standard area factors are not applied as the regional differences in costs are accounted for within the two fee schedules.

The dental premium rates for each product within each region are shown in Appendix I.

Oral Contraceptives Covered in Full

EHP is not applying a premium differential to remove cost sharing for oral contraceptive coverage. Consistent with HHS assumptions, the expectation is that the increased claims due to the enhanced oral contraceptive coverage will be balanced by reduced maternity claims leading to a minimal overall impact.

Dependent through age 29

Current policy forms EXHP-190 and EXHP-191 extend coverage for students and dependents through the age of 29. These are filed and approved with state tracking number 200909112 and SERFF number HNMN-126284396. EHP is applying an impact consistent with that filing, 1.9% of the premium for family and subscriber/children contract types only.

Domestic Partner

The addition of domestic partner coverage will have no impact on the 2014 premium rates. The addition of a domestic partner will be handled similar to the addition of a spouse. The additional coverage will adjust the contract type of the subscriber. For example, a single contract will become a subscriber + spouse contract with the addition of a domestic partner.

Calculation of Final Premium Rates for Subsequent Quarters

The premium rates do not roll for Individual business. The final premium rates of all plans are shown in the rate manual exhibits.

Projected Loss Ratios

Based on the expected expenses and revenues within the individual risk pool, the projected loss ratios meet or exceed minimum requirements of 82%. The projected loss ratio is 88.1%.

Other Required Information

Based on the requirements in Prior Approval Review Standards, this rate application includes:

- Rate manuals for each rating region
- List of all plans included in the risk pool (Appendix ll). This listing includes the following: on/off exchange, product name, metal tier level, metal AV value, and description of the cost sharing features and benefits
- AV calculations from HHS AV calculator for each plan
- Required Exhibits
  - Exhibit 1: General Information about the Rate Adjustment Submission
  - Exhibit 7: Historical Data by each Policy Form Included in Rate Adjustment Filing
  - Exhibit 8: Index Rate/Plan Design Level Adjustment Worksheet
  - Exhibit 9: Summary of Average Claim Trend and Administrative Expenses and Profit Margin Included in Current Rate Application
  - HHS's Unified Rate Review Template

Actuarial Certification

I am an Associate of the Society of Actuaries, a Member of the American Academy of Actuaries, and I meet the Academy's qualification standards for rendering opinions with regard to health rate filings. I certify that this rate submission is in compliance with the applicable laws and regulations of the State of New York and that expected loss ratios meet or exceed minimum requirements. I attest that this submission is in compliance with the appropriate Actuarial Standards of Practice documents, specifically ASOP #5, ASOP #8, ASOP #12, ASOP #23, ASOP #25, and ASOP #41.

Based on my review of the underlying experience, expected contracting changes for the rating period and assuming the experience period enrollment distribution between rating pools remains relatively constant in the rating period, it is my opinion that, in aggregate, the proposed rates are adequate to cover total projected expenses, reasonable in relation to the benefits provided and are neither excessive nor unfairly discriminatory.

[redacted] May 9, 2013

[redacted]AAA

Excellus Health Plan **Appendix I**

2014 Individual Dental Premium Rates

		2014 Dental Premium Rates				
Region	Dental Plan Name	Single	Sub & Spouse	Sub & Child(ren)	Family	Child
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Rochester	Non-Standard	6.54	13.08	11.12	18.64	2.69
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Syracuse	Non-Standard	6.54	13.08	11.12	18.64	2.69
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Utica/Watertown	Non-Standard	6.54	13.08	11.12	18.64	2.69
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Mid-Hudson	Non-Standard	6.54	13.08	11.12	18.64	2.69
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Albany	Non-Standard	6.54	13.08	11.12	18.64	2.69
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Buffalo	Non-Standard	5.76	11.52	9.79	16.42	2.37

Excellus Health Plan
Individual On- and Off-Exchange - List of Plans and Cost Sharing Features

Brand	Product Name	Network	Standard vs Non Standard	On Exchange	Plan Design	Metal AV	Metal Level	Single Ded	Coins INN	PCP Copay	SPC Copay	Single OOP Max	I/P Copay	ER	Ambulance	Rx	Urgent Care	OP Copay /Amb Surg	High Tech Image	Lab	PT/OT/ST	Adult Eye Exam	Adult Eyewear	Adult Hearing Aids	DME
Excellus BCBS	Excellus BCBS Platinum Standard IND PP	Excellus BCBS EPO/PPO	Non-Standard	No	Copay	0.881	Platinum	0	0	15	35	2000	500	100	100	$10/$30/$60	55	100	35	35	25	NC	NC	10% Coins	10% Coins
Univera Healthcare	Univera Platinum Standard IND PPO	Univera PPO	Non-Standard	No	Copay	0.881	Platinum	0	0	15	35	2000	500	100	100	$10/$30/$60	55	100	35	35	25	NC	NC	10% Coins	10% Coins

Pediatric Dental is option with all plans Dependent through age 29 is option for all plans but Catastrophic Covered in Full Oral Contraceptives and Domestic Partner Coverage are options in all plans and child only is available in all Standard options except Catastrophic.

Excellus Health Plan, Inc.
Excellus BCBS, Univera Healthcare

Actuarial Value Calculations

Individual On and Off Exchange

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, ON-Exchange & OFF-Exchange Market	
Marketing Name:	[redacted]	[redacted]
Associated HIOS IDs:	[redacted]	[redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare
Market:	Individual, ON-Exchange & OFF-Exchange Market
Marketing Name:	[redacted] [redacted]
Associated HIOS IDs:	[redacted] [redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, OFF-Exchange Market Only	
Marketing Name:	Excellus BCBS Platinum Standard IND PPO	Univera Platinum Standard IND PPO
Associated HIOS IDs:	78124NY1090001-00	78124NY1100001-00
	78124NY1090002-00	78124NY1100002-00
	78124NY1090003-00	78124NY1100003-00
	78124NY1090004-00	78124NY1100004-00
	78124NY1090005-00	78124NY1100005-00
	78124NY1090006-00	78124NY1100006-00

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

COMPANY NAME	Excellus BlueCrossBlueShield / Univera Healthcare
MARKET	Individual, OFF-Exchange Market Only
Marketing Name	Platinum Standard IND PPO

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	Platinum

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

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$35.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑		
Skilled Nursing Facility	☑	☐		$500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.280%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.750%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$43.70	☑	☑		

Options for Additional Benefit Design Limits:

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

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.1%
Metal Tier:	Platinum

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, ON-Exchange & OFF-Exchange Market	
Marketing Name:	Excellus BCBS Gold Standard	Univera Gold Standard
Associated HIOS IDs:	[redacted]	[redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, ON-Exchange & OFF-Exchange Market	
Marketing Name:	Excellus BCBS Gold Select	Univera Gold Select
Associated HIOS IDs:	[redacted]	[redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name: Excellus BlueCrossBlueShield / Univera HealthCare
Market: Individual, ON-Exchange & OFF-Exchange Market
Marketing Name: Excellus BCBS Bassett Gold Select

Associated HIOS IDs: [redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, ON-Exchange & OFF-Exchange Market	
Marketing Name:	Excellus BCBS Silver Standard	Univera Silver Standard
Associated HIOS IDs:	[redacted]	[redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, ON-Exchange & OFF-Exchange Market	
Marketing Name:	Excellus BCBS Silver Select	Univera Silver Select
Associated HIOS IDs:	[redacted]	[redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, ON-Exchange & OFF-Exchange Market	
Marketing Name:	Excellus BCBS Bronze Standard	Univera Bronze Standard
Associated HIOS IDs:	[redacted]	[redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, ON-Exchange & OFF-Exchange Market	
Marketing Name:	Excellus BCBS Bronze Select	Univera Bronze Select
Associated HIOS IDs:	[redacted]	[redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, ON-Exchange Only	
Marketing Name:	Excellus BCBS Base	Univera Base
Associated HIOS IDs:	[redacted]	[redacted]

Variant	Variant ID
Off Exchange	-00
[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, Silver Subsidy	
AV Input	SilSub (200-250% FPL)	
Marketing Name:	Excellus BCBS Silver Standard	Univera Silver Standard
Associated HIOS IDs:	[redacted]	[redacted]

AV Input	SilSub (150-200% FPL)	
Marketing Name:	Excellus BCBS Silver Standard	Univera Silver Standard
Associated HIOS IDs:	[redacted]	[redacted]

AV Input	SilSub (100-150% FPL)	
Marketing Name:	Excellus BCBS Silver Standard	Univera Silver Standard
Associated HIOS IDs:	[redacted]	[redacted]

[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, Native American Subsidy	
Marketing Name:	Excellus BCBS Native American Subsidy	Univera Native American Subsidy
Associated HIOS IDs:	[redacted]	[redacted]

Company Name:	Excellus BlueCrossBlueShield / Univera HealthCare	
Market:	Individual, Silver Subsidy	
AV Input	3.1 Non-Standard Sil Sub 4 HDHP A	
Marketing Name:	Excellus BCBS Silver Select	Univera Silver Select
Associated HIOS IDs:	[redacted]	[redacted]

AV Input	3.1 Non-Standard Sil Sub 5 HDHP A	
Marketing Name:	Excellus BCBS Silver Select	Univera Silver Select
Associated HIOS IDs:	[redacted]	[redacted]

AV Input	3.1 Non-Standard Sil Sub 6 HDHP A	
Marketing Name:	Excellus BCBS Silver Select	Univera Silver Select
Associated HIOS IDs:	[redacted]	[redacted]

[redacted]	[redacted]
NA $0 Cost Share	-02
NA IHS Network Plan	-03
Silver Subsidy 73%	-04
Silver Subsidy 87%	-05
Silver Subsidy 94%	-06

Data Collection Template

Company Legal Name:	**Excellus Health Plan, Inc**	State:	**NY**
HIOS Issuer ID:	**78124**	Market:	**Individual**
Effective Date of Rate Change(s):	**1/1/2014**		

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 10/1/2011 to 9/30/2012

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$740,116,014	$305.64	100.00%
Incurred Claims in Experience Period	$676,102,922	279.21	91.35%
Allowed Claims:	$773,688,245	319.51	104.54%
Index Rate of Experience Period		$402.16	
Experience Period Member Months	2,421,513		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 27 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	75.36	$10,814.94	$67.91	1.300	0.978	1.033	1.040	107.03	$11,372.89	$101.44	107.03	$11,372.89	$101.44
Outpatient Hospital	Services	2,109.99	489.70	86.10	1.300	0.978	1.033	1.040	2,996.87	514.96	128.61	2996.87	514.96	128.61
Professional	Services	7,266.55	155.01	93.87	1.300	0.978	1.033	1.040	10,320.84	163.01	140.20	10320.84	163.01	140.20
Other Medical	Services	937.72	124.21	9.71	1.300	0.978	1.033	1.040	1,331.86	130.62	14.50	1331.86	130.62	14.50
Capitation	Services	23.06	155.01	0.30	1.300	0.978	1.033	1.040	32.75	163.01	0.44	32.75	163.01	0.44
Prescription Drug	Prescriptions	10,857.04	68.10	61.62	1.300	0.978	1.052	1.035	15,264.49	74.57	94.86	15264.49	74.57	94.86
Total				$319.51							$480.04			$480.04

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	100.00%	0.00%	$480.04	$186,087,552
Paid to Allowed Average Factor in Projection Period			0.694	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$333.28	$129,194,629
Projected Risk Adjustments PMPM			0.00	388
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$333.28	$129,194,241
Projected ACA reinsurance recoveries, net of rein prem, PMPM			37.93	14,703,489
Projected Incurred Claims			$295.35	$114,490,752
Administrative Expense Load		9.57%	33.91	13,143,866
Profit & Risk Load		2.00%	7.08	2,746,093
Taxes & Fees		5.04%	17.86	6,923,932
Single Risk Pool Gross Premium Avg. Rate, PMPM			$354.20	$137,304,643
Index Rate for Projection Period			$559.40	
% increase over Experience Period			15.89%	
% Increase, annualized:			6.77%	
Projected Member Months				387,648

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Product-Plan Data Collection

Company Legal Name: **Excellus Health Plan, Inc**
HIOS Issuer ID: **78124**
Effective Date of Rate Change(s): **1/1/2014**

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

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		Blue Choice 25	Blue Choice 30	HealthyBlue Roch	SimplyBlue Roch	althyBlue HDHP Ro	mplyBlue HDHP Ro	HMO Blue 25 CNY	HMO Blue 30 CNY	HealthyBlue CNY	SimplyBlue CNY	althyBlue HDHP C	mplyBlue HDHP CN	HMO Blue 25 UW	HMO Blue 30 UW	HealthyBlue UW	SimplyBlue UW	ealthyBlue HDHP U	mplyBlue HDHP U	SSA PPO	SSA Indemnity	Direct Pay HMO	Direct Pay POS
Product ID:		78124NY003	78124NY004	78124NY011	78124NY012	78124NY009	78124NY010	78124NY005	78124NY006	78124NY040	78124NY041	78124NY038	78124NY039	78124NY034	78124NY035	78124NY069	78124NY070	78124NY067	78124NY068	78124NY013	78124NY019	78124NY020	78124NY025
Metal:		Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic	Catastrophic
AV Metal Value		0.834	0.732	0.837	0.837	0.704	0.704	0.852	0.748	0.863	0.863	0.669	0.669	0.855	0.751	0.849	0.849	0.668	0.668	0.743	0.688	0.916	0.913
AV Pricing Value		0.770	0.656	0.795	0.795	0.520	0.520	0.776	0.682	0.814	0.814	0.476	0.476	0.779	0.684	0.789	0.789	0.479	0.479	0.610	0.472	0.825	0.856
Plan Type:		HMO	HMO	PPO	PPO	PPO	PPO	HMO	HMO	PPO	PPO	PPO	PPO	HMO	HMO	PPO	PPO	PPO	PPO	PPO	Indemnity	HMO	POS
Plan Name		Blue Choice 25	Blue Choice 30	HealthyBlue Roch	SimplyBlue Roch	HealthyBlue HDHP Roch	SimplyBlue HDHP Roch	HMO Blue 25 CNY	HMO Blue 30 CNY	HealthyBlue CNY	SimplyBlue CNY	HealthyBlue HDHP CNY	SimplyBlue HDHP CNY	HMO Blue 25 UW	HMO Blue 30 UW	HealthyBlue UW	SimplyBlue UW	HealthyBlue HDHP UW	SimplyBlue HDHP UW	SSA PPO	SSA Indemnity	Direct Pay HMO	Direct Pay POS
Plan ID (Standard Component ID):		78124NY0030001	78124NY0040001	78124NY0110001	78124NY0120001	78124NY0090001	78124NY0100001	78124NY0050001	78124NY0060001	78124NY0400001	78124NY0410001	78124NY0380001	78124NY0390001	78124NY0340001	78124NY0350001	78124NY0690001	78124NY0700001	78124NY0670001	78124NY0680001	78124NY0130001	78124NY0190001	78124NY0200001	78124NY0250001
Exchange Plan?		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2		12.50%	12.50%	12.50%	12.50%	12.50%	12.50%	11.50%	11.50%	11.50%	11.50%	11.50%	11.50%	12.50%	12.50%	12.50%	12.50%	12.50%	12.50%	12.50%	12.50%	5.40%	5.40%
Historical Rate Increase - Calendar Year - 1		12.50%	12.50%	11.00%	11.00%	19.55%	19.55%	9.86%	9.86%	8.98%	8.98%	15.02%	15.02%	12.50%	12.50%	8.35%	8.35%	16.80%	16.80%	12.50%	12.50%	-7.55%	-7.55%
Historical Rate Increase - Calendar Year 0		12.50%	12.50%	9.61%	9.61%	16.97%	16.97%	12.30%	12.30%	11.48%	11.48%	14.32%	14.32%	12.50%	12.50%	11.07%	11.07%	15.60%	15.60%	14.10%	14.10%	4.74%	4.74%
Effective Date of Proposed Rates		1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Proj'd Per Rate Change % (over Exper. Period)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Product Threshold Rate Increase %		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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

Plan ID (Standard Component ID):	Total	78124NY0030001	78124NY0040001	78124NY0110001	78124NY0120001	78124NY0090001	78124NY0100001	78124NY0050001	78124NY0060001	78124NY0400001	78124NY0410001	78124NY0380001	78124NY0390001	78124NY0340001	78124NY0350001	78124NY0690001	78124NY0700001	78124NY0670001	78124NY0680001	78124NY0130001	78124NY0190001	78124NY0200001	78124NY0250001
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$327.96	$479.09	$522.65	$442.79	$362.19	$218.02	$201.73	$725.25	$0.00	$471.90	$456.64	$252.68	$236.10	$516.81	$601.17	$555.17	$500.93	$276.71	$259.12	$260.35	$463.25	$1,184.58	$1,253.47
Projected Member Months	387,648	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Section III: Experience Period Information

	Plan ID (Standard Component ID):	Total	78124NY0030001	78124NY0040001	78124NY0110001	78124NY0120001	78124NY0090001	78124NY0100001	78124NY0050001	78124NY0060001	78124NY0400001	78124NY0410001	78124NY0380001	78124NY0390001	78124NY0340001	78124NY0350001	78124NY0690001	78124NY0700001	78124NY0670001	78124NY0680001	78124NY0130001	78124NY0190001	78124NY0200001	78124NY0250001
Premium Information	Average Rate PMPM	$272.56	$479.09	$522.65	$442.79	$362.19	$218.02	$201.73	$725.25	$0.00	$471.90	$456.64	$252.68	$236.10	$516.81	$601.17	$555.17	$500.93	$276.71	$259.12	$260.35	$463.25	$1,184.58	$1,253.47
	Member Months	380,762	1,319	19	11,308	8,617	19,618	17,383	29	0	6,518	6,682	7,537	12,345	185	18	4,981	3,686	5,124	8,082	17,015	5,156	4,426	3,409
	Total Premium (TP)	$103,781,353	$631,917	$9,930	$5,007,111	$3,120,998	$4,277,065	$3,506,610	$21,032	$0	$3,075,820	$3,051,291	$1,904,461	$2,914,601	$95,610	$10,821	$2,765,299	$1,846,426	$1,417,859	$2,094,187	$4,429,779	$2,388,535	$5,242,967	$4,273,093
	EHB basis or full portion of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Claims Information	Total Allowed Claims (TAC)	$114,239,528	$863,621	$1,412	$6,573,605	$4,419,070	$4,252,498	$2,947,782	$34,237	$0	$4,547,546	$2,706,777	$1,888,547	$2,169,511	$160,122	$677	$3,796,592	$2,181,154	$1,555,083	$1,608,493	$6,747,737	$3,648,517	$4,494,777	$4,331,611
	EHB basis or full portion of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Allowed Claims which are not the issuer's obligation:	$15,341,208	$82,814	$464	$633,058	$409,830	$763,736	$527,617	$4,584	$0	$519,254	$245,958	$504,764	$220,567	$14,291	$173	$412,310	$173,238	$392,884	$124,272	$1,653,050	$638,755	$205,865	$170,588
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0																						
	Portion of above payable by HHS on behalf of insured person, as %	0.00%																						
	Total Incurred claims, payable with issuer funds	$98,898,320	$780,807	$948	$5,940,547	$4,009,240	$3,488,761	$2,420,165	$29,652	$0	$4,028,292	$2,460,819	$1,383,783	$1,948,945	$145,832	$507	$3,384,283	$2,007,916	$1,162,200	$1,484,222	$5,094,687	$3,009,761	$4,288,912	$4,161,024
	Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Incurred Claims PMPM	$259.74	$591.97	$49.88	$525.34	$465.27	$177.83	$139.23	$1,022.48	#DIV/0!	$618.03	$368.28	$183.60	$157.87	$788.28	$28.15	$679.44	$544.74	$226.81	$183.65	$299.42	$583.74	$969.03	$1,220.60
	Allowed Claims PMPM	$300.03	$654.75	$74.29	$581.32	$512.83	$216.77	$169.58	$1,180.57	#DIV/0!	$697.69	$405.08	$250.57	$175.74	$865.53	$37.63	$762.21	$591.74	$303.49	$199.02	$396.58	$707.63	$1,015.54	$1,270.64
	EHB portion of Allowed Claims, PMPM	$300.03	$654.75	$74.29	$581.32	$512.83	$216.77	$169.58	$1,180.57	#DIV/0!	$697.69	$405.08	$250.57	$175.74	$865.53	$37.63	$762.21	$591.74	$303.49	$199.02	$396.58	$707.63	$1,015.54	$1,270.64

Section IV: Projected (12 months following effective date)

	Plan ID (Standard Component ID):	Total	78124NY0030001	78124NY0040001	78124NY0110001	78124NY0120001	78124NY0090001	78124NY0100001	78124NY0050001	78124NY0060001	78124NY0400001	78124NY0410001	78124NY0380001	78124NY0390001	78124NY0340001	78124NY0350001	78124NY0690001	78124NY0700001	78124NY0670001	78124NY0680001	78124NY0130001	78124NY0190001	78124NY0200001	78124NY0250001
Premium Information	Average Rate PMPM	$327.96	$479.09	$522.65	$442.79	$362.19	$218.02	$201.73	$725.25	$0.00	$471.90	$456.64	$252.68	$236.10	$516.81	$601.17	$555.17	$500.93	$276.71	$259.12	$260.35	$463.25	$1,184.58	$1,253.47
	Member Months	387,648	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Premium (TP)	$127,134,110	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB basis or full portion of TP, [see instructions]	100.00%																						
	state mandated benefits portion of TP that are other than EHB	0.00%																						
	Other benefits portion of TP	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Claims Information	Total Allowed Claims (TAC)	$177,758,245																						
	EHB basis or full portion of TAC, [see instructions]	100.00%																						
	state mandated benefits portion of TAC that are other than EHB	0.00%																						
	Other benefits portion of TAC	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Allowed Claims which are not the issuer's obligation	$71,885,648																						
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0																						
	insured person, as %	0.00%																						
	Total Incurred claims, payable with issuer funds	$105,872,597	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0																						
	Net Amt of Risk Adj	$0																						

HealthyNY HMO	HealthyNY EPO	ValuMed	Valumed Plus	ExcellusBCBS EPO Copay										ExcellusBCBS EPO Hybrid											
78124NY022	78124NY023	78124NY028	78124NY029	78124NY088										78124NY089											
Catastrophic	Catastrophic	Catastrophic	Catastrophic	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Gold	Gold	Gold	Gold	Gold	Gold	Silver	Silver	Silver	Silver	Silver	Silver
0.916	0.804	0.667	0.697	0.881	0.881	0.881	0.881	0.881	0.881	0.890	0.890	0.890	0.890	0.791	0.791	0.791	0.791	0.791	0.791	0.707	0.707	0.707	0.707	0.707	0.707
0.779	0.658	0.469	0.573	0.848	0.848	0.848	0.848	0.848	0.848	0.855	0.855	0.855	0.855	0.763	0.763	0.763	0.763	0.763	0.763	0.682	0.682	0.682	0.682	0.682	0.682
HMO	EPO	Indemnity	Indemnity	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
HealthyNY HMO	HealthyNY EPO	ValuMed	Valumed Plus	Excellus BCBS Platinum Standard	Excellus BCBS Platinum Standard	Excellus BCBS Platinum Standard	Excellus BCBS Platinum Standard	Excellus BCBS Platinum Standard	Excellus BCBS Platinum Standard	Excellus BCBS Platinum Select	Excellus BCBS Platinum Select	Excellus BCBS Platinum Select	Excellus BCBS Platinum Select	Excellus BCBS Gold Standard	Excellus BCBS Gold Standard	Excellus BCBS Gold Standard	Excellus BCBS Gold Standard	Excellus BCBS Gold Standard	Excellus BCBS Gold Standard	Excellus BCBS Silver Standard	Excellus BCBS Silver Standard	Excellus BCBS Silver Standard	Excellus BCBS Silver Standard	Excellus BCBS Silver Standard	Excellus BCBS Silver Standard
78124NY0220001	78124NY0230001	78124NY0280001	78124NY0290001	[redacted]																					
No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5.40%	5.40%	5.40%	5.40%	0.00%										0.00%											
0.31%	0.31%	-7.55%	-7.55%	0.00%										0.00%											
3.61%	3.61%	23.53%	23.53%	0.00%										0.00%											
1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
0.00%	0.00%	0.00%	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00%										0.00%											

78124NY0220001	78124NY0230001	78124NY0280001	78124NY0290001	[redacted]																					
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

$278.23	$177.99	$117.30	$318.15	[redacted]																					
0	0	0	0	0	0	[redacted]	0	0	0	0	0	0	0	0	0	[redacted]	0	0	0	0	0	[redacted]	0	0	0

78124NY0220001	78124NY0230001	78124NY0280001	78124NY0290001	[redacted]																					
$278.23	$177.99	$117.30	$318.15																						
81,239	124,124	15,748	16,194																						
$22,603,499	$22,093,060	$1,847,292	$5,152,090	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
100.00%	100.00%	100.00%	100.00%																						
0.00%	0.00%	0.00%	0.00%																						
0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
$30,477,456	$17,289,853	$1,337,023	$6,205,826																						
100.00%	100.00%	100.00%	100.00%																						
0.00%	0.00%	0.00%	0.00%																						
0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
$4,258,218	$2,782,488	$8,540	$593,896																						
[redacted]				$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
[redacted]				#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
$26,219,239	$14,507,366	$1,328,484	$5,611,931	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
$322.74	$116.88	$84.36	$346.54	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
$375.16	$139.30	$84.90	$383.22	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
$375.16	$139.30	$84.90	$383.22	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

78124NY0220001	78124NY0230001	78124NY0280001	78124NY0290001	[redacted]																					
$278.23	$177.99	$117.30	$318.15	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$0.00	$0.00	$0.00	$0.00	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
-	-	-	-	-	-	[redacted]	-	-	-	-	-	-	-	-	-	[redacted]	-	-	-	-	-	[redacted]	-	-	-
$0	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0
				100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
				0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
				$0	$0	[redacted]	$0	$0	$0	$0	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0
				100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
				0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
				$0	$0	[redacted]	$0	$0	$0	$0	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0
[redacted]				$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
[redacted]				#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!
$0	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0

				ExcellusBCBS EPO HDHP 78124NY090														ExcellusBCBS EPO Base 78124NY091		Bassett EPO 78124NY092					
Gold	Gold	Gold	Gold	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Catastrophic	Catastrophic	Gold	Gold	Gold	Gold	Platinum	Platinum
[redacted]																									
[redacted]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
				0.00%														0.00%		0.00%					
				0.00%														0.00%		0.00%					
				0.00%														0.00%		0.00%					
1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
				0.00%														#DIV/0!		#DIV/0!					
[redacted]																									
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
[redacted]																									
0	0	36	0	0	0	[redacted]	0	0	0	0	0	[redacted]	0	0	0	[redacted]	0	0	0	0	0	0	0	0	0
[redacted]																									
$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
[redacted]																									
#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
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100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
[redacted]																									
0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
[redacted]																									
#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	[redacted]
[redacted]																									

[redacted]								Univera EPO Hybrid																	
								78124NY094																	
Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Gold	Gold	Gold	Gold	Gold	Gold	Silver	Silver	Silver	Silver	Silver	Silver	Gold	Gold	Gold	Gold	Bronze	Bronze
0.881	0.881	0.881	0.881	0.890	0.890	0.890	0.890	0.791	0.791	0.791	0.791	0.791	0.791	0.707	0.707	0.707	0.707	0.707	0.707	0.788	0.788	0.788	0.788	0.620	0.620
0.848	0.848	0.848	0.848	0.855	0.855	0.855	0.855	0.763	0.763	0.763	0.763	0.763	0.763	0.682	0.682	0.682	0.682	0.682	0.682	0.764	0.764	0.764	0.764	0.392	0.392
EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
Univera Platinum Standard	Univera Platinum Standard	Univera Platinum Standard	Univera Platinum Standard	Univera Platinum Select	Univera Platinum Select	Univera Platinum Select	Univera Platinum Select	Univera Gold Standard	Univera Gold Standard	Univera Gold Standard	Univera Gold Standard	Univera Gold Standard	Univera Gold Standard	Univera Silver Standard	Univera Silver Standard	Univera Silver Standard	Univera Silver Standard	Univera Silver Standard	Univera Silver Standard	Univera Gold Select	Univera Gold Select	Univera Gold Select	Univera Gold Select	Univera Bronze Standard	Univera Bronze Standard
[redacted]																									
			[redacted]												0.00%										
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Univera EPO HDHP 78124NY095												Univera EPO Base 78124NY096		Excellus PPO Copay 78124NY109						Univera PPO Copay 78124NY110					
Bronze	Bronze	Bronze	Bronze	Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Catastrophic	Catastrophic	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum
0.620	0.620	0.620	0.620	0.684	0.684	0.684	0.684	0.592	0.592	0.592	0.592	0.580	0.580	0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881
0.392	0.392	0.392	0.392	0.490	0.490	0.490	0.490	0.343	0.343	0.343	0.343	0.360	0.360	0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862
EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Univera Bronze Standard	Univera Bronze Standard	Univera Bronze Standard	Univera Bronze Standard	Univera Silver Select	Univera Silver Select	Univera Silver Select	Univera Silver Select	Univera Bronze Select	Univera Bronze Select	Univera Bronze Select	Univera Bronze Select	Univera Base	Univera Base	Excellus BCBS Platinum Standard IND PPO	Excellus BCBS Platinum Standard IND PPO	Excellus BCBS Platinum Standard IND PPO	Excellus BCBS Platinum Standard IND PPO	Excellus BCBS Platinum Standard IND PPO	Excellus BCBS Platinum Standard IND PPO	Univera Platinum Standard IND PPO	Univera Platinum Standard IND PPO	Univera Platinum Standard IND PPO	Univera Platinum Standard IND PPO	Univera Platinum Standard IND PPO	Univera Platinum Standard IND PPO
[redacted]														78124NY1090001	78124NY1090002	78124NY1090003	78124NY1090004	78124NY1090005	78124NY1090006	78124NY1100001	78124NY1100002	78124NY1100003	78124NY1100004	78124NY1100005	78124NY1100006
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No
0.00%												0.00%		0.00%						0.00%					
0.00%												0.00%		0.00%						0.00%					
0.00%												0.00%		0.00%						0.00%					
1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
0.00%												#DIV/0!		#DIV/0!						#DIV/0!					

[redacted]														78124NY1090001	78124NY1090002	78124NY1090003	78124NY1090004	78124NY1090005	78124NY1090006	78124NY1100001	78124NY1100002	78124NY1100003	78124NY1100004	78124NY1100005	78124NY1100006
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
[redacted]														$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01
62,196	0	0	0	0	0	3,972	0	0	0	4,668	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

[redacted]														78124NY1090001	78124NY1090002	78124NY1090003	78124NY1090004	78124NY1090005	78124NY1090006	78124NY1100001	78124NY1100002	78124NY1100003	78124NY1100004	78124NY1100005	78124NY1100006
$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
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$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
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#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
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[redacted]														78124NY1090001	78124NY1090002	78124NY1090003	78124NY1090004	78124NY1090005	78124NY1090006	78124NY1100001	78124NY1100002	78124NY1100003	78124NY1100004	78124NY1100005	78124NY1100006
[redacted]	-	-	-	-	-	[redacted]	-	-	-	[redacted]	-	-	-	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01	$448.01
[redacted]	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
[redacted]	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
[redacted]	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0												
0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!												
[redacted]	$0	$0	$0	$0	$0	[redacted]	$0	$0	$0	[redacted]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:

Company submitting the rate adjustment request	Company Type	Org. Type	Company NAIC Code
Excellus Health Plan, Inc	Article 43 and HMO	Not-for-Profit	55107

Company mailing address: 165 Court Street, Rochester, NY 14647

B. Contact Person:

Rate filing contact person name, title	Contact phone number	Contact Email address
[redacted]	[redacted]	[redacted]

C. Actuarial Contact (If different from above):

Actuary name, title	Actuary phone number	Actuary Email address

D. New Rate Information (See Note #1):

New rate applicability period	New rate effective date	SERFF Tracking Number
January 1, 2014-December 31 2014	1/1/2014	EXHP-128987637

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

F. Provide responses for the following questions:

	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	Yes. This is a new business submission in support of Exchange plans to be effective 1/1/2014. Model language has been used for all submitted plans.
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	Yes. The Broker Commission schedule included in the rate manuals in this submission has been submitted separately under SERFF ID EXHP-128990122.
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3).	Not Applicable
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes.
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefiling.	Not Applicable

Notes:

(1) It is recommended that a rate filing application subject to §3231(e)(1) or §4308(c) of the New York Insurance Law be submitted at least 150 days before the proposed effective date.
It is recommended that a rate adjustment application not be submitted more than 180 days prior to the proposed effective date.
It is recommended that a rate adjustment application not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing.

(2) A rate adjustment filing submitted pursuant to §3231(e)(1) or §4308(c) of the New York Insurance Law should **not** include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing, a new form or a revision to an existing form, must be a separate filing from the rate adjustment filing.

Use the following SERFF filing types for rate adjustment filings:

* For a rate adjustment filing pursuant to §3231(e)(1): Rate Adjustment pursuant to §3231(e)(1)
* For a rate adjustment filing pursuant to §4308(c): Rate Adjustment pursuant to §4308(c)
* For all other prior approval filings: Normal Pre-Approval

(3) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment application is submitted to the Insurance Department.

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

Company Name: Excellus Health Plan, Inc.
NAIC Code: 55107
SERFF Number: EXHP-128987637
Market Segment: IND

A. Complete a separate ROW each base medical policy form included in the rate adjustment filing.
- Information requested applies to New York State business only.
- Include riders that may be available with that policy form in each policy form response.
- Insert additional rows as needed to include all base medical policy forms included in a particular rating pool.
- Add a row with the aggregate values for that entire rating pool and enter an appropriate identifier in column 2. Skip a row between the different rating pools.

B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG HMO Upstate if rating pools vary by rating region.

C. Market segment refers to Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healhty NY (HNY-IND), Small Group Healthy NY (HNY SG). Use the drop down list to enter the market segment.

D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans and Base+Supplemental. Indicate appropriate designation for policy form, etc.

E. The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department). Include a region identifier in this column if needed.

F. Note that many cells include a drop down list. Use the drop down list for entries.

G. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).

H. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form												Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identifier	3. Effective date of rate change (MM/DD/YY)	4. Market Segment	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change		14.1 Beginning Date of the experience period (MM/DD/YY)	14.2 Ending Date of the experience period (MM/DD/YY)	14.3 Member months for experience period	14.4 Earned premiums for experience period ($)	14.5 Standardized earned premiums for experience period ($)	14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from 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) ($)	
EXC-C-10, EXR-C-32	[Copay; Hybrid] PPO Base Plan	[Healthy Blue; Simply Blue] PPO [Hybrid; Copay]	Syracuse	01/01/14	SP	PPO	Yes	Closed	676	1,130	XX	10/01/11	09/30/12	13,200	6,127,111	6,810,711	6,412,587	6,489,111	0	0	600,481	XX
EXC-C-11, EXR-C-32, EXR-C-34	HSA Base Plan	[Healthy Blue; Simply Blue] HDHP	Syracuse	01/01/14	SP	HDHP	Yes	Closed	944	1,681	XX	10/01/11	09/30/12	19,882	4,819,062	5,774,339	3,279,168	3,332,728	0	0	902,852	XX
EXC-8	Blue Choice [$25, $30] Basic Contract	Blue Choice [$25, $30] Copay Plan	Syracuse	01/01/14	SP	HMO	No	Closed	1	2	XX	10/01/11	09/30/12	29	21,032	22,567	28,946	29,652	0	0	1,309	XX
EXC-C-10, EXR-C-32	[Copay; Hybrid] PPO Base Plan	[Healthy Blue; Simply Blue] PPO [Hybrid; Copay]	Rochester	01/01/14	SP	PPO	Yes	Closed	908	1,550	XX	10/01/11	09/30/12	16,702	6,503,317	7,385,425	8,505,702	8,571,174	0	0	758,877	XX
EXC-C-11, EXR-C-32, EXR-C-34	HSA Base Plan	[Healthy Blue; Simply Blue] HDHP	Rochester	01/01/14	SP	HDHP	Yes	Closed	1,316	2,544	XX	10/01/11	09/30/12	27,376	5,512,096	6,806,978	4,183,473	4,235,063	0	0	1,244,081	XX
EXC-8	Blue Choice [25, 30] Basic Contract	Blue Choice [$25, $30] Copay Plan	Rochester	01/01/14	SG	HMO	No	Closed	73	115	XX	10/01/11	09/30/12	1,320	626,571	694,802	761,555	765,556	0	0	60,198	XX
EXC-C-10, EXR-C-32	[Copay; Hybrid] PPO Base Plan	[Healthy Blue; Simply Blue] PPO [Hybrid; Copay]	Utica Group	01/01/14	SG	PPO	Yes	Closed	451	708	XX	10/01/11	09/30/12	8,667	4,611,725	5,289,399	5,341,117	5,392,199	0	0	393,923	XX
EXC-C-11, EXR-C-32, EXR-C-34	HSA Base Plan	[Healthy Blue; Simply Blue] HDHP	Utica Group	01/01/14	SG	HDHP	Yes	Closed	627	1,101	XX	10/01/11	09/30/12	13,206	3,512,047	4,331,612	2,612,631	2,646,421	0	0	599,894	XX
EXC-8	HMO Blue [25, 30] Basic Contract	HMO Blue [$25, $30] Copay Plan	Utica Group	01/01/14	SG	HMO	No	Closed	9	16	XX	10/01/11	09/30/12	203	106,431	114,862	134,914	146,338	0	0	9,178	XX
EXC-C-10, EXR-C-32	[Copay; Hybrid] PPO Base Plan	[Healthy Blue; Simply Blue] PPO [Hybrid; Copay]	Univera Group	01/01/14	SG	PPO	Yes	Closed	148	245	XX	10/01/11	09/30/12	3,223	1,624,792	1,767,957	1,359,570	1,378,613	0	0	146,158	XX
EXC-C-11, EXR-C-32, EXR-C-34	HSA Base Plan	[Healthy Blue; Simply Blue] HDHP	Univera Group	01/01/14	SG	HDHP	Yes	Closed	432	794	XX	10/01/11	09/30/12	9,625	2,271,579	2,752,503	1,609,776	1,673,863	0	0	436,828	XX
UNC-7	HMO	Value Plus	Univera Group	01/01/14	SG	HMO	Yes	Closed	1	1	XX	10/01/11	09/30/12	18	15,277	16,060	16,184	16,198	0	0	814	XX
EX-36 Rev.2	Comprehensive Low Deductible and PPO Plans	SSA - Comprehensive Low Deductible and PPO Plans	SSA	01/01/14	SG	Comprehensive	No	Closed	29	1,592	XX	10/01/11	09/30/12	22,171	6,818,314	7,048,001	8,064,586	8,104,448	0	0	786,598	XX
EXHP-36	HMO	Healthy New York Part A,B	Healthy New	01/01/14	HNY-SG	HMO	No	Closed	3	353	XX	10/01/11	09/30/12	4,197	1,036,338	1,037,106	1,086,752	1,089,974	(181,360)	0	104,204	XX
EXHP-38	HMO	Healthy New York Part A,B	Healthy New	01/01/14	HNY-IND	HMO	No	Closed	1,524	1,788	XX	10/01/11	09/30/12	22,690	5,860,362	5,865,081	9,388,353	9,428,280	(2,905,194)	0	564,356	XX
EXHP-80	Exclusive Provider Organization	HNY B EPO Group	Healthy New	01/01/14	HNY-IND	EPO	No	Closed	2,396	2,939	XX	10/01/11	09/30/12	33,294	5,595,262	5,599,503	4,094,551	4,144,870	(922,236)	0	824,968	XX
EXHP-81	Exclusive Provider Organization	HNY B EPO Group	Healthy New	01/01/14	HNY-SG	EPO	No	Closed	3	727	XX	10/01/11	09/30/12	8,185	1,241,925	1,242,836	1,056,126	1,071,534	(143,964)	0	202,441	XX
EXHP-78	HMO	Healthy New York Plus (Trade Act 2)	Healthy New	01/01/14	HNY-IND	HMO	No	Closed	5	7	XX	10/01/11	09/30/12	114	42,919	42,958	20,442	20,641	0	0	2,878	XX
EXHP-36	HMO	Healthy New York Part A,B	Healthy New	01/01/14	HNY-SG	HMO	No	Closed	2	269	XX	10/01/11	09/30/12	3,111	962,958	963,710	1,388,078	1,391,533	(282,675)	0	77,319	XX
EXHP-38	HMO	Healthy New York Part A,B	Healthy New	01/01/14	HNY-IND	HMO	No	Closed	1,169	1,481	XX	10/01/11	09/30/12	12,789	4,062,307	4,065,547	5,941,483	5,963,021	(1,290,446)	0	317,813	XX
EXHP-80	Exclusive Provider Organization	HNY B EPO Direct	Healthy New	01/01/14	HNY-IND	EPO	No	Closed	1,364	1,780	XX	10/01/11	09/30/12	19,735	3,795,507	3,798,349	2,762,054	2,794,591	(350,368)	0	488,787	XX
EXHP-81	Exclusive Provider Organization	HNY B EPO Group	Healthy New	01/01/14	HNY-SG	EPO	No	Closed	2	595	XX	10/01/11	09/30/12	6,604	1,234,817	1,235,715	1,088,266	1,103,025	(195,949)	0	163,309	XX
EXHP-78	HMO	Healthy New York Plus (Trade Act 2)	Healthy New	01/01/14	HNY-IND	HMO	No	Closed	12	15	XX	10/01/11	09/30/12	215	133,619	133,727	57,847	58,251	0	0	5,351	XX
EXHP-36	HMO	Healthy New York Part A,B	Healthy New	01/01/14	HNY-SG	HMO	No	Closed	1	270	XX	10/01/11	09/30/12	3,059	925,176	925,855	869,082	874,135	(146,427)	0	75,704	XX
EXHP-38	HMO	Healthy New York Part A,B	Healthy New	01/01/14	HNY-IND	HMO	No	Closed	653	810	XX	10/01/11	09/30/12	10,080	3,128,257	3,130,726	4,893,376	4,908,843	(995,795)	0	250,333	XX
EXHP-80	Exclusive Provider Organization	HNY B EPO Direct	Healthy New	01/01/14	HNY-IND	EPO	Yes	Closed	1,129	1,500	XX	10/01/11	09/30/12	16,914	3,353,399	3,355,897	2,794,088	2,832,658	(503,137)	0	418,847	XX
EXHP-81	Exclusive Provider Organization	HNY B EPO Group	Healthy New	01/01/14	HNY-SG	EPO	Yes	Closed	2	628	XX	10/01/11	09/30/12	7,312	1,365,535	1,367,605	1,146,310	1,159,525	(193,568)	0	181,117	XX
EXHP-78	HMO	Healthy New York Plus (Trade Act 2)	Healthy New	01/01/14	HNY-IND	HMO	No	Closed	8	11	XX	10/01/11	09/30/12	162	101,841	101,920	39,987	38,579	0	0	4,023	XX
EXHP-36	HMO	Healthy New York Part A,B	Healthy New	01/01/14	HNY-SG	HMO	No	Closed	1	316	XX	10/01/11	09/30/12	277	52,798	52,818	39,932	40,913	(9,929)	0	6,564	XX
EXHP-38	HMO	Healthy New York Part A,B	Healthy New	01/01/14	HNY-IND	HMO	No	Closed	1,393	1,638	XX	10/01/11	09/30/12	584	124,313	124,363	1,479,261	1,482,223	(488,330)	0	14,022	XX
EXHP-80	Exclusive Provider Organization	HNY B EPO Direct	Healthy New	01/01/14	HNY-IND	EPO	No	Closed	1,857	2,293	XX	10/01/11	09/30/12	25,838	4,463,723	4,467,267	3,803,121	3,832,128	(711,509)	0	641,236	XX
EXHP-81	Exclusive Provider Organization	HNY B EPO Group	Healthy New	01/01/14	HNY-SG	EPO	No	Closed	1	557	XX	10/01/11	09/30/12	6,242	1,042,892	1,043,669	802,295	806,650	(216,885)	0	154,625	XX
EXHP-78	HMO	Healthy New York Plus (Trade Act 2)	Healthy New	01/01/14	HNY-IND	HMO	No	Closed	27	40	XX	10/01/11	09/30/12	507	259,155	259,353	147,547	150,296	(37,031)	0	12,574	XX
HNYCERT-44MG	HMO	Healthy New York Option A (Group Certificate)	Healthy New	01/01/14	HNY-SG	EPO	No	Closed	0	0	XX	10/01/11	09/30/12	3,844	964,411	965,195	922,313	930,561	(153,481)	0	95,731	XX
HNYCONTRACT-44I	HMO	Healthy New York Option A (Individual)	Healthy New	01/01/14	HNY-IND	EPO	No	Closed	0	0	XX	10/01/11	09/30/12	19,610	4,949,046	4,953,168	7,911,546	7,973,431	(1,640,777)	0	488,742	XX
EXHP-41	HMO	Standardized Individual HMO Contract	Mandated	01/01/14	IND	HMO	No	Closed	193	214	XX	10/01/11	09/30/12	2,498	2,877,600	2,819,152	3,030,063	3,040,528	(402,446)	0	61,981	XX
EXHP-42	HMO	Standardized Individual POS Contract	Mandated	01/01/14	IND	HMO	Yes	Closed	93	98	XX	10/01/11	09/30/12	1,174	1,497,780	1,466,706	2,670,815	2,678,908	(361,174)	0	29,170	XX
EXHP-41	HMO	Standardized Individual HMO Contract	Mandated	01/01/14	IND	HMO	No	Closed	38	40	XX	10/01/11	09/30/12	416	547,624	536,786	354,724	355,180	(47,930)	0	10,307	XX
EXHP-42	HMO	Standardized Individual POS Contract	Mandated	01/01/14	IND	HMO	No	Closed	130	153	XX	10/01/11	09/30/12	1,773	2,085,554	2,042,996	1,814,739	1,817,613	(250,739)	0	44,020	XX
EXHP-41	HMO	Standardized Individual HMO Contract	Mandated	01/01/14	IND	HMO	No	Closed	31	37	XX	10/01/11	09/30/12	421	594,002	581,233	608,315	609,172	(103,688)	0	10,480	XX
EXHP-42	HMO	Standardized Individual POS Contract	Mandated	01/01/14	IND	HMO	No	Closed	19	21	XX	10/01/11	09/30/12	257	414,584	405,995	152,891	153,027	(27,447)	0	6,385	XX
EXHP-41UN	HMO	Standardized Individual HMO Contract	Mandated	01/01/14	IND	HMO	No	Closed	78	85	XX	10/01/11	09/30/12	1,091	1,223,741	1,197,051	919,934	920,236	(82,139)	0	27,180	XX
EXHP-42UN	HMO	Standardized Individual POS Contract	Mandated	01/01/14	IND	HMO	No	Closed	17	18	XX	10/01/11	09/30/12	205	275,175	269,851	166,550	166,677	(15,842)	0	5,076	XX
LI-1, 6, 7, 8, 9, 10, TR-153	Exclusive Provider Organization	Valumed Plus	ValuMed/ValuM	01/01/14	IND	EPO	No	Closed	790	1,253	XX	10/01/11	09/30/12	15,748	1,847,292	1,808,990	1,313,493	1,328,484	0	0	391,295	XX
VP-1 Rev. 2	Exclusive Provider Organization	Valumed	ValuMed/ValuM	01/01/14	IND	EPO	No	Closed	564	637	XX	10/01/11	09/30/12	7,377	2,189,639	2,146,007	2,511,763	2,543,369	0	0	182,915	XX
VP-1 Rev. 2	Exclusive Provider Organization	Valumed Plus	ValuMed/ValuM	01/01/14	IND	EPO	No	Closed	244	273	XX	10/01/11	09/30/12	3,182	1,112,721	1,090,786	1,033,785	1,048,775	0	0	78,823	XX
VP-1 Rev.2	Exclusive Provider Organization	Valumed Plus	ValuMed/ValuM	01/01/14	IND	EPO	No	Closed	159	162	XX	10/01/11	09/30/12	2,101	762,532	746,422	728,833	739,279	0	0	52,255	XX
VP-1 Rev.2	Exclusive Provider Organization	Valumed Plus	ValuMed/ValuM	01/01/14	IND	EPO	No	Closed	275	277	XX	10/01/11	09/30/12	3,534	1,087,197	1,064,943	1,275,934	1,280,507	0	0	87,742	XX

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

		Data Item for Specified Base	First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)											Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										
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) ($)		16.1 Beginning date of the experience period (MM/DD/YY)	16.2 Ending Date of the experience period (MM/DD/YY)	16.3 Member months for experience period	16.4 Earned premiums for experience period ($)	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) ($)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
EXC-C-10, EXR-C-32	[Copay; Hybrid] PPO Base Plan	[Healthy Blue; Simply Blue] PPO [Hybrid; Copay]	10/01/10	09/30/11	10,073	4,370,352	5,147,655	4,006,256	4,008,365	0	0	440,849	XX	10/01/09	09/30/10	7,273.00	2,817,702	3,498,800	3,256,244	3,256,636	0	0	315,639	XX
EXC-C-11, EXR-C-32, EXR-C-34	HSA Base Plan	[Healthy Blue; Simply Blue] HDHP	10/01/10	09/30/11	16,286	3,573,207	4,637,905	2,269,124	2,270,260	0	0	713,114	XX	10/01/09	09/30/10	8,244.00	1,750,260	2,277,173	897,157	897,157	0	0	357,829	XX
EXC-8	Blue Choice [25, 30] Basic Contract	Blue Choice [$25, $30] Copay Plan	10/01/10	09/30/11	61	40,555	45,457	43,836	43,837	0	0	2,666	XX	10/01/09	09/30/10	110.00	65,233	81,053	49,819	49,819	0	0	4,770	XX
EXC-C-10, EXR-C-32	[Copay; Hybrid] PPO Base Plan	[Healthy Blue; Simply Blue] PPO [Hybrid; Copay]	10/01/10	09/30/11	15,439	5,103,246	6,223,235	5,208,909	5,211,068	0	0	675,486	XX	10/01/09	09/30/10	11,400.00	3,269,410	4,197,340	3,413,858	3,414,080	0	0	495,079	XX
EXC-C-11, EXR-C-32, EXR-C-34	HSA Base Plan	[Healthy Blue; Simply Blue] HDHP	10/01/10	09/30/11	20,967	3,641,802	4,918,118	2,134,993	2,137,472	0	0	917,990	XX	10/01/09	09/30/10	9,694.00	1,526,001	2,037,798	1,151,856	1,151,937	0	0	421,022	XX
EXC-8	Blue Choice [25, 30] Basic Contract	Blue Choice [$25, $30] Copay Plan	10/01/10	09/30/11	998	386,902	484,421	212,961	213,031	0	0	43,623	XX	10/01/09	09/30/10	2,146.00	751,684	1,027,000	644,334	644,337	0	0	93,057	XX
EXC-C-10, EXR-C-32	[Copay; Hybrid] PPO Base Plan	[Healthy Blue; Simply Blue] PPO [Hybrid; Copay]	10/01/10	09/30/11	7,755	3,723,839	4,643,852	3,688,163	3,689,384	0	0	339,291	XX	10/01/09	09/30/10	6,611.00	2,825,787	3,699,812	3,113,687	3,113,755	0	0	286,906	XX
EXC-C-11, EXR-C-32, EXR-C-34	HSA Base Plan	[Healthy Blue; Simply Blue] HDHP	10/01/10	09/30/11	10,212	2,417,957	3,296,086	1,728,902	1,728,674	0	0	447,215	XX	10/01/09	09/30/10	4,418.00	1,017,781	1,380,919	663,364	663,380	0	0	191,786	XX
EXC-8	HMO Blue [25, 30] Basic Contract	HMO Blue [$25, $30] Copay Plan	10/01/10	09/30/11	273	116,338	135,571	208,564	208,566	0	0	11,944	XX	10/01/09	09/30/10	277.00	107,573	140,762	169,359	169,359	0	0	12,016	XX
EXC-C-10, EXR-C-32	[Copay; Hybrid] PPO Base Plan	[Healthy Blue; Simply Blue] PPO [Hybrid; Copay]	10/01/10	09/30/11	3,608	1,561,604	1,809,395	1,942,799	1,944,534	0	0	157,874	XX	10/01/09	09/30/10	3,138.00	1,182,169	1,529,073	1,033,781	1,033,932	0	0	136,174	XX
EXC-C-11, EXR-C-32, EXR-C-34	HSA Base Plan	[Healthy Blue; Simply Blue] HDHP	10/01/10	09/30/11	8,996	1,950,650	2,515,446	1,831,992	1,833,615	0	0	393,692	XX	10/01/09	09/30/10	6,851.00	1,323,739	1,789,064	944,395	944,447	0	0	297,334	XX
UNC-7	HMO	Value Plus	10/01/10	09/30/11	55	37,318	44,134	79,124	79,124	0	0	2,406	XX	10/01/09	09/30/10	104.00	49,344	68,017	30,724	30,724	0	0	4,509	XX
EX-36 Rev.2	Comprehensive Low Deductible and PPO Plans	SSA - Comprehensive Low Deductible and PPO Plans	10/01/10	09/30/11	28,776	8,274,771	9,654,614	8,736,678	8,739,183	0	0	814,843	XX	10/01/09	09/30/10	36,124.00	9,753,180	12,859,144	9,310,062	9,311,665	0	0	966,564	XX
EXHP-36	HMO	Healthy New York Part A,B	10/01/10	09/30/11	4,730	1,121,680	1,143,266	1,081,300	1,081,414	0	0	153,335	XX	10/01/09	09/30/10	5,235.00	1,104,440	1,216,710	1,130,677	1,130,677	0	0	227,112	XX
EXHP-38	HMO	Healthy New York Part A,B	10/01/10	09/30/11	25,192	6,349,497	6,460,844	9,855,139	9,856,033	(3,935,518)	0	815,122	XX	10/01/09	09/30/10	28,633.00	6,587,141	7,242,533	11,266,443	11,266,443	-3,562,366	0	1,242,184	XX
EXHP-80	Exclusive Provider Organization	HNY B EPO Group	10/01/10	09/30/11	31,163	5,247,392	5,335,944	3,811,065	3,811,041	(1,232,655)	0	1,007,786	XX	10/01/09	09/30/10	31,413.00	4,963,266	5,441,713	3,915,285	3,915,318	-1,054,766	0	1,362,929	XX
EXHP-81	Exclusive Provider Organization	HNY B EPO Group	10/01/10	09/30/11	7,561	1,160,362	1,179,323	970,347	970,384	0	0	242,791	XX	10/01/09	09/30/10	7,040.00	1,004,934	1,104,104	752,814	752,820	0	0	305,451	XX
EXHP-78	HMO	Healthy New York Plus (Trade Act 2)	10/01/10	09/30/11	131	56,983	58,444	108,456	108,488	0	0	4,107	XX	10/01/09	09/30/10	59.00	26,486	30,320	29,049	29,050	0	0	2,560	XX
EXHP-36	HMO	Healthy New York Part A,B	10/01/10	09/30/11	3,773	1,171,459	1,195,717	1,209,541	1,209,573	0	0	123,117	XX	10/01/09	09/30/10	4,495.00	1,269,163	1,396,841	1,407,680	1,407,680	0	0	195,002	XX
EXHP-38	HMO	Healthy New York Part A,B	10/01/10	09/30/11	14,197	4,454,306	4,532,687	6,671,947	6,672,213	0	0	459,952	XX	10/01/09	09/30/10	16,463.00	4,739,850	5,216,515	6,117,530	6,117,530	0	0	714,188	XX
EXHP-80	Exclusive Provider Organization	HNY B EPO Direct	10/01/10	09/30/11	19,696	3,794,550	3,857,858	2,714,496	2,715,141	0	0	636,354	XX	10/01/09	09/30/10	19,929.00	3,605,880	3,950,036	2,201,284	2,201,284	0	0	864,683	XX
EXHP-81	Exclusive Provider Organization	HNY B EPO Group	10/01/10	09/30/11	6,293	1,181,194	1,200,679	918,310	918,497	0	0	203,096	XX	10/01/09	09/30/10	6,722.00	1,179,141	1,295,919	1,067,623	1,067,623	0	0	291,634	XX
EXHP-78	HMO	Healthy New York Plus (Trade Act 2)	10/01/10	09/30/11	272	169,049	173,153	125,791	125,797	0	0	8,619	XX	10/01/09	09/30/10	55.00	29,787	33,869	29,880	29,881	0	0	2,387	XX
EXHP-36	HMO	Healthy New York Part A,B	10/01/10	09/30/11	3,116	933,101	951,119	965,426	965,446	0	0	101,239	XX	10/01/09	09/30/10	3,810.00	1,025,918	1,131,875	1,080,946	1,080,946	0	0	165,279	XX
EXHP-38	HMO	Healthy New York Part A,B	10/01/10	09/30/11	11,635	3,559,868	3,620,817	5,104,388	5,104,614	0	0	377,610	XX	10/01/09	09/30/10	14,049.00	3,940,899	4,340,157	5,885,069	5,885,069	0	0	609,451	XX
EXHP-80	Exclusive Provider Organization	HNY B EPO Direct	10/01/10	09/30/11	16,279	3,243,113	3,296,468	2,151,175	2,151,785	0	0	525,670	XX	10/01/09	09/30/10	17,474.00	3,244,712	3,558,380	2,681,247	2,681,247	0	0	758,129	XX
EXHP-81	Exclusive Provider Organization	HNY B EPO Group	10/01/10	09/30/11	6,969	1,312,963	1,337,537	943,491	943,762	0	0	224,649	XX	10/01/09	09/30/10	7,140.00	1,269,708	1,394,198	1,052,210	1,052,210	0	0	309,775	XX
EXHP-78	HMO	Healthy New York Plus (Trade Act 2)	10/01/10	09/30/11	122	75,550	76,787	19,770	19,770	0	0	3,701	XX	10/01/09	09/30/10	47.00	28,545	32,613	19,656	19,656	0	0	2,040	XX
EXHP-36	HMO	Healthy New York Part A,B	10/01/10	09/30/11	47	9,267	9,510	11,649	11,652	0	0	1,534	XX	10/01/09	09/30/10	50.00	9,029	10,102	476	476	0	0	2,169	XX
EXHP-38	HMO	Healthy New York Part A,B	10/01/10	09/30/11	198	40,061	40,880	12,352	12,354	0	0	6,375	XX	10/01/09	09/30/10	257.00	48,135	53,395	23,036	23,036	0	0	11,149	XX
EXHP-80	Exclusive Provider Organization	HNY B EPO Direct	10/01/10	09/30/11	28,002	4,823,110	4,913,193	3,209,288	3,209,423	0	0	909,299	XX	10/01/09	09/30/10	28,723.00	4,620,741	5,092,719	2,969,247	2,969,247	0	0	1,246,244	XX
EXHP-81	Exclusive Provider Organization	HNY B EPO Group	10/01/10	09/30/11	5,820	965,604	981,954	848,352	848,387	0	0	187,031	XX	10/01/09	09/30/10	5,738.00	883,126	973,973	494,625	494,625	0	0	248,954	XX
EXHP-78	HMO	Healthy New York Plus (Trade Act 2)	10/01/10	09/30/11	555	274,380	278,270	138,705	138,746	0	0	17,536	XX	10/01/09	09/30/10	433.00	191,114	210,574	144,193	144,194	0	0	18,790	XX
HNYCERT-44MG	HMO	Healthy New York Option A (Group Certificate)	10/01/10	09/30/11	4,624	1,111,884	1,131,753	1,267,571	1,267,856	0	0	150,270	XX	10/01/09	09/30/10	5,475.00	1,195,055	1,329,866	1,731,003	1,731,014	0	0	237,513	XX
HNYCONTRACT-44I	HMO	Healthy New York Option A (Individual)	10/01/10	09/30/11	25,679	6,338,997	6,460,465	9,737,687	9,740,717	0	0	841,017	XX	10/01/09	09/30/10	33,604.00	7,672,747	8,539,310	11,046,736	11,046,800	0	0	1,457,777	XX
EXHP-41	HMO	Standardized Individual HMO Contract	10/01/10	09/30/11	2,867	3,466,587	3,251,488	3,277,651	3,277,753	(423,544)	0	93,142	XX	10/01/09	09/30/10	3,017.00	3,379,134	3,438,262	2,630,986	2,631,007	-288,133	0	130,875	XX
EXHP-42	HMO	Standardized Individual POS Contract	10/01/10	09/30/11	1,392	1,849,916	1,736,252	2,898,395	2,898,422	(286,748)	0	45,171	XX	10/01/09	09/30/10	1,603.00	1,936,640	1,974,868	2,172,440	2,172,455	-221,508	0	69,537	XX
EXHP-41	HMO	Standardized Individual HMO Contract	10/01/10	09/30/11	448	625,439	588,009	563,654	563,687	(45,812)	0	14,711	XX	10/01/09	09/30/10	523.00	648,225	659,071	741,435	741,435	0	0	22,688	XX
EXHP-42	HMO	Standardized Individual POS Contract	10/01/10	09/30/11	1,968	2,436,337	2,290,181	2,397,960	2,398,145	(217,889)	0	63,784	XX	10/01/09	09/30/10	2,272.00	2,548,608	2,617,692	2,451,857	2,451,857	0	0	98,559	XX
EXHP-41	HMO	Standardized Individual HMO Contract	10/01/10	09/30/11	507	745,490	699,325	773,161	773,161	(73,153)	0	16,512	XX	10/01/09	09/30/10	707.00	956,857	975,400	1,039,129	1,039,129	0	0	30,666	XX
EXHP-42	HMO	Standardized Individual POS Contract	10/01/10	09/30/11	370	605,020	569,570	105,696	105,696	(9,935)	0	12,189	XX	10/01/09	09/30/10	574.00	841,210	865,647	199,927	199,927	0	0	24,897	XX
EXHP-41UN	HMO	Standardized Individual HMO Contract	10/01/10	09/30/11	1,385	1,612,653	1,517,108	1,246,183	1,246,165	(177,504)	0	45,196	XX	10/01/09	09/30/10	1,824.00	1,943,215	2,028,949	1,239,287	1,239,287	-133,832	0	79,112	XX
EXHP-42UN	HMO	Standardized Individual POS Contract	10/01/10	09/30/11	229	319,886	300,582	256,690	256,688	(37,070)	0	7,408	XX	10/01/09	09/30/10	286.00	367,829	380,353	456,294	456,294	-48,548	0	12,408	XX
LI-1, 6, 7, 8, 9, 10, TR-153	Exclusive Provider Organization	Valumed Plus	10/01/10	09/30/11	17,750	2,191,259	2,060,001	1,965,957	1,965,860	0	0	576,410	XX	10/01/09	09/30/10	20,070.00	2,240,517	2,351,279	2,427,512	2,427,530	0	0	870,717	XX
VP-1 Rev. 2	Exclusive Provider Organization	Valumed	10/01/10	09/30/11	8,301	2,525,574	2,418,244	2,272,614	2,272,627	0	0	270,591	XX	10/01/09	09/30/10	9,734.00	2,446,058	2,765,046	2,073,010	2,073,028	0	0	422,256	XX
VP-1 Rev. 2	Exclusive Provider Organization	Valumed Plus	10/01/10	09/30/11	3,139	1,132,854	1,080,366	899,928	900,095	0	0	101,163	XX	10/01/09	09/30/10	3,328.00	1,017,600	1,145,386	1,157,620	1,157,620	0	0	144,374	XX
VP-1 Rev.2	Exclusive Provider Organization	Valumed Plus	10/01/10	09/30/11	2,458	905,795	864,502	630,595	630,821	0	0	79,483	XX	10/01/09	09/30/10	2,698.00	838,817	943,836	715,680	715,680	0	0	117,044	XX
VP-1 Rev.2	Exclusive Provider Organization	Valumed Plus	10/01/10	09/30/11	4,017	1,268,805	1,212,645	1,249,827	1,249,827	0	0	130,310	XX	10/01/09	09/30/10	4,313.00	1,148,667	1,281,509	1,557,053	1,557,053	0	0	187,127	XX

Exhibit 8 Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Excellus Health Plan Inc.
NAIC Code: 55107
SERFF Number: EXHP-128987637
Market Segment: Individual On/Off Exchange

Separate co umn for each plan design (on or off Exchange)

Line #	General																
1	Product*	ExcellusBCBS EPO Copay															
2	Product ID*	78124NY088															
3	Metal Level (or catastrophic)*																
4	AV Metal Value (HHS Calculator)*																
5	AV Pricing Value (total, risk pool experience based)*																
6	Plan Type*																
7	Plan Name*																
8	Plan ID*																
9	Exchange Plan?*																

Th s field shou d be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate	
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period	
10B	Member-Months for Latest Experience Period	
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor	
11	Average Pricing Actuarial Value reflected in experience period	
12	**AV Adjusted Experience Period Index Rate (L10/L11)**	

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate	
13	Impact of adjusting experience period data to EHB benefit level	
14	Market wide adjustment for changes in provider network **	
15	Market wide adjustment for fee schedule changes **	
16	Market wide adjustment for utilization management changes **	
17	Impact on risk pool of changes in expected covered membership risk characteristics *	
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only**	
19	Adjustment for changes in distr bution of risk pool membersh p by rating regions **	
20	Federal R sk Adjustment Program Impac (less than 1.00 to reflect a recovery	
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery	
22	Impact of adjustments due to experience period cla m data not being sufficiently credible	
23	Claim trend projection factor (midpo nt of exper ence period to mid point of rate applicabi ity period)	
24	Other 1 (specify)	
25	Other 2 (specify)	
26	Other 3 (specify)	
27	**Impact of Market Wide Adjustments (product L13 through L26)**	

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments																
28	Pricing actuarial value (without induced demand factor) #																
29	Pricing actuarial value (only the induced demand factor) #																
30	Impact of provider network characteristics ##																
31	Impact of delivery system characteristics ##																
32	Impact of utilization management practices ##																
33	Benefits in additional to EHB (greater than 1.00)																
34	Administrative costs (excluding Exchange user fees and profits)																
35	Profit/Contribution to surplus margins																
36	Impact of eligibi ity categories (catastrophic plans only)																
37	Addition of Out of Network Benefit Option (e.g. POS or PPO if applicable																
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY																
39	Other 1 (specify)																
40	Other 2 (specify)																
41	**Impact of Plan Level Adjustments (product L28 through L40)**																

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

Beyond what is reflected in Market Wide adjustments

42	**TOTAL PROJECTED INDEX RATE (L12 x L27 x L41)**																

Exhibit 8 Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Excellus Health Plan Inc.
NAIC Code: 55107
SERFF Number: EXHP-128987637
Market Segment: Individual On/Off Exchange

Line #	General																
1	Product*	ExcellusBCBS EPO Hybrid															ExcellusBCBS EPO HDHP
2	Product ID*	78124NY089															78124NY090
3	Metal Level (or catastrophic)*																
4	AV Metal Value (HHS Calculator)*																
5	AV Pricing Value (total, risk pool experience based)*																
6	Plan Type*																
7	Plan Name*																
8	Plan ID*																
9	Exchange Plan?*																
	Th s field shou d be the same as used in the Unified Rate Review Template, Worksheet 2																
	Experience Period Index Rate																
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period																
10B	Member-Months for Latest Experience Period																
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor																
11	Average Pricing Actuarial Value reflected in experience period																
12	**AV Adjusted Experience Period Index Rate (L10/L11)**																
	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate																
13	Impact of adjusting experience period data to EHB benefit level																
14	Market wide adjustment for changes in provider network **																
15	Market wide adjustment for fee schedule changes **																
16	Market wide adjustment for utilization management changes **																
17	Impact on risk pool of changes in expected covered membership risk characteristics *																
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only**																
19	Adjustment for changes in distr bution of risk pool membersh p by rating regions **																
20	Federal R sk Adjustment Program Impac (less than 1.00 to reflect a recovery																
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery																
22	Impact of adjustments due to experience period cla m data not being sufficiently credible																
23	Claim trend projection factor (midpo nt of exper ence period to mid point of rate applicabi ity period)																
24	Other 1 (specify)																
25	Other 2 (specify)																
26	Other 3 (specify)																
27	**Impact of Market Wide Adjustments (product L13 through L26)**																
	** Not Included in Claim Trend Adjustment																
	Plan Level Adjustments																
28	Pricing actuarial value (without induced demand factor) #																
29	Pricing actuarial value (only the induced demand factor) #																
30	Impact of provider network characteristics ##																
31	Impact of delivery system characteristics ##																
32	Impact of utilization management practices ##																
33	Benefits in additional to EHB (greater than 1.00)																
34	Administrative costs (excluding Exchange user fees and profits)																
35	Profit/Contribution to surplus margins																
36	Impact of eligibi ity categories (catastrophic plans only)																
37	Addition of Out of Network Benefit Option (e.g. POS or PPO if applicable																
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY																
39	Other 1 (specify)																
40	Other 2 (specify)																
41	**Impact of Plan Level Adjustments (product L28 through L40)**																
	# Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupatio																
	## Beyond what is reflected in Market Wide adjustments																
42	**TOTAL PROJECTED INDEX RATE (L12 x L27 x L41)**																

Exhibit 8 Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Excellus Health Plan Inc.
NAIC Code: 55107
SERFF Number: EXHP-128987637
Market Segment: Individual On/Off Exchange

Line #	General																
1	Product*							ExcellusBCBS EPO Base		Bassett EPO				Univera E			
2	Product ID*							78124NY091		78124NY092				78124			
3	Metal Level (or catastrophic)*																
4	AV Metal Value (HHS Calculator)*																
5	AV Pricing Value (total, risk pool experience based)*																
6	Plan Type*																
7	Plan Name*																
8	Plan ID*																
9	Exchange Plan?*																
	Th s field shou d be the same as used in the Unified Rate Review Template, Worksheet 2																
	Experience Period Index Rate																
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period																
10B	Member-Months for Latest Experience Period																
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor																
11	Average Pricing Actuarial Value reflected in experience period																
12	**AV Adjusted Experience Period Index Rate (L10/L11)**																
	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate																
13	Impact of adjusting experience period data to EHB benefit level																
14	Market wide adjustment for changes in provider network **																
15	Market wide adjustment for fee schedule changes **																
16	Market wide adjustment for utilization management changes **																
17	Impact on risk pool of changes in expected covered membership risk characteristics *																
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only**																
19	Adjustment for changes in distr bution of risk pool membersh p by rating regions **																
20	Federal R sk Adjustment Program Impac (less than 1.00 to reflect a recovery																
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery																
22	Impact of adjustments due to experience period cla m data not being sufficiently credible																
23	Claim trend projection factor (midpo nt of exper ence period to mid point of rate applicabi ity period)																
24	Other 1 (specify)																
25	Other 2 (specify)																
26	Other 3 (specify)																
27	**Impact of Market Wide Adjustments (product L13 through L26)**																
	** Not Included in Claim Trend Adjustment																
	Plan Level Adjustments																
28	Pricing actuarial value (without induced demand factor) #																
29	Pricing actuarial value (only the induced demand factor) #																
30	Impact of provider network characteristics ##																
31	Impact of delivery system characteristics ##																
32	Impact of utilization management practices ##																
33	Benefits in additional to EHB (greater than 1.00)																
34	Administrative costs (excluding Exchange user fees and profits)																
35	Profit/Contribution to surplus margins																
36	Impact of eligibi ity categories (catastrophic plans only)																
37	Addition of Out of Network Benefit Option (e.g. POS or PPO if applicable																
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY																
39	Other 1 (specify)																
40	Other 2 (specify)																
41	**Impact of Plan Level Adjustments (product L28 through L40)**																
	# Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupatio																
	## Beyond what is reflected in Market Wide adjustments																
42	**TOTAL PROJECTED INDEX RATE (L12 x L27 x L41)**																

Exhibit 8 Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Excellus Health Plan Inc.
NAIC Code: 55107
SERFF Number: EXHP-128987637
Market Segment: Individual On/Off Exchange

Line #	General																	
1	Product*	PO Copay					Univera EPO Hybrid											
2	Product ID*	NY093					78124NY094											
3	Metal Level (or catastrophic)*																	
4	AV Metal Value (HHS Calculator)*																	
5	AV Pricing Value (total, risk pool experience based)*																	
6	Plan Type*																	
7	Plan Name*																	
8	Plan ID*																	
9	Exchange Plan?*																	

Th s field shou d be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate																	
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period																	
10B	Member-Months for Latest Experience Period																	
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor																	
11	Average Pricing Actuarial Value reflected in experience period																	
12	**AV Adjusted Experience Period Index Rate (L10/L11)**																	

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate																	
13	Impact of adjusting experience period data to EHB benefit level																	
14	Market wide adjustment for changes in provider network **																	
15	Market wide adjustment for fee schedule changes **																	
16	Market wide adjustment for utilization management changes **																	
17	Impact on risk pool of changes in expected covered membership risk characteristics *																	
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only**																	
19	Adjustment for changes in distr bution of risk pool membersh p by rating regions **																	
20	Federal R sk Adjustment Program Impac (less than 1.00 to reflect a recovery																	
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery																	
22	Impact of adjustments due to experience period cla m data not being sufficiently credible																	
23	Claim trend projection factor (midpo nt of exper ence period to mid point of rate applicabi ity period)																	
24	Other 1 (specify)																	
25	Other 2 (specify)																	
26	Other 3 (specify)																	
27	**Impact of Market Wide Adjustments (product L13 through L26)**																	

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments																	
28	Pricing actuarial value (without induced demand factor) #																	
29	Pricing actuarial value (only the induced demand factor) #																	
30	Impact of provider network characteristics ##																	
31	Impact of delivery system characteristics ##																	
32	Impact of utilization management practices ##																	
33	Benefits in additional to EHB (greater than 1.00)																	
34	Administrative costs (excluding Exchange user fees and profits)																	
35	Profit/Contribution to surplus margins																	
36	Impact of eligibi ity categories (catastrophic plans only)																	
37	Addition of Out of Network Benefit Option (e.g. POS or PPO if applicable																	
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY																	
39	Other 1 (specify)																	
40	Other 2 (specify)																	
41	**Impact of Plan Level Adjustments (product L28 through L40)**																	

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

Beyond what is reflected in Market Wide adjustments

42	**TOTAL PROJECTED INDEX RATE (L12 x L27 x L41)**																	

Exhibit 8 Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Excellus Health Plan Inc.
NAIC Code: 55107
SERFF Number: EXHP-128987637
Market Segment: Individual On/Off Exchange

Line #	General																
1	Product*					Univera EPO HDHP											
2	Product ID*					78124NY095											
3	Metal Level (or catastrophic)*																
4	AV Metal Value (HHS Calculator)*																
5	AV Pricing Value (total, risk pool experience based)*																
6	Plan Type*																
7	Plan Name*																
8	Plan ID*																
9	Exchange Plan?*																
	Th s field shou d be the same as used in the Unified Rate Review Template, Worksheet 2																
	Experience Period Index Rate																
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period																
10B	Member-Months for Latest Experience Period																
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor																
11	Average Pricing Actuarial Value reflected in experience period																
12	**AV Adjusted Experience Period Index Rate (L10/L11)**																
	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate																
13	Impact of adjusting experience period data to EHB benefit level																
14	Market wide adjustment for changes in provider network **																
15	Market wide adjustment for fee schedule changes **																
16	Market wide adjustment for utilization management changes **																
17	Impact on risk pool of changes in expected covered membership risk characteristics *																
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only**																
19	Adjustment for changes in distr bution of risk pool membersh p by rating regions **																
20	Federal R sk Adjustment Program Impac (less than 1.00 to reflect a recovery																
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery																
22	Impact of adjustments due to experience period cla m data not being sufficiently credible																
23	Claim trend projection factor (midpo nt of exper ence period to mid point of rate applicabi ity period)																
24	Other 1 (specify)																
25	Other 2 (specify)																
26	Other 3 (specify)																
27	**Impact of Market Wide Adjustments (product L13 through L26)**																
	** Not Included in Claim Trend Adjustment																
	Plan Level Adjustments																
28	Pricing actuarial value (without induced demand factor) #																
29	Pricing actuarial value (only the induced demand factor) #																
30	Impact of provider network characteristics ##																
31	Impact of delivery system characteristics ##																
32	Impact of utilization management practices ##																
33	Benefits in additional to EHB (greater than 1.00)																
34	Administrative costs (excluding Exchange user fees and profits)																
35	Profit/Contribution to surplus margins																
36	Impact of eligibi ity categories (catastrophic plans only)																
37	Addition of Out of Network Benefit Option (e.g. POS or PPO if applicable																
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY																
39	Other 1 (specify)																
40	Other 2 (specify)																
41	**Impact of Plan Level Adjustments (product L28 through L40)**																
	# Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupatio																
	## Beyond what is reflected in Market Wide adjustments																
42	**TOTAL PROJECTED INDEX RATE (L12 x L27 x L41)**																

Exhibit 8 Index Rate/Plan Design Level Adjustment Worksheet

Company Name: Excellus Health Plan Inc.
NAIC Code: 55107
SERFF Number: EXHP-128987637
Market Segment: Individual On/Off Exchange

Line #	General																
1	Product*		Univera EPO Base		Excellus PPO Copay						Univera PPO Copay					
2	Product ID*		78124NY096		78124NY109						78124NY110					
3	Metal Level (or catastrophic)*				Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum	Platinum
4	AV Metal Value (HHS Calculator)*				0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881	0.881
5	AV Pricing Value (total, risk pool experience based)*				0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862	0.862
6	Plan Type*				PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
7	Plan Name*				Excellus BCBS Platinum Standard	Excellus BCBS Platinum Standard	Excellus BCBS Platinum Standard	Excellus BCBS Platinum Standard	Exce lus BCBS Platinum Standard	Excellus BCBS Platinum Standard	Univera Platinum Standard IND PPO	Univera Platinum Standard ND PPO	Univera Platinum Standard IND PPO	Univera Platinum Standard IND PPO	Univera Platinum Standard IND PPO	Univera Platinum Standard IND PPO
8	Plan ID*				78124NY1090001	78124NY1090002	78124NY1090003	78124NY1090004	78124NY1090005	78124NY1090006	78124NY1100001	78124NY1100002	78124NY1100003	78124NY1100004	78124NY1100005	78124NY1100006
9	Exchange Plan?*				No	No	No	No	No	No	No	No	No	No	No	No
	Th s field shou d be the same as used in the Unified Rate Review Template, Worksheet 2															
	Experience Period Index Rate															
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period															
10B	Member-Months for Latest Experience Period															
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor															
11	Average Pricing Actuarial Value reflected in experience period															
12	**AV Adjusted Experience Period Index Rate (L10/L11)**				**402.16**	**402.16**	**402.16**	**402.16**	**402.16**	**402.16**	**402.16**	**402.16**	**402.16**	**402.16**	**402.16**	**402.16**
	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate															
13	Impact of adjusting experience period data to EHB benefit level															
14	Market wide adjustment for changes in provider network **															
15	Market wide adjustment for fee schedule changes **															
16	Market wide adjustment for utilization management changes **															
17	Impact on risk pool of changes in expected covered membership risk characteristics *															
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only**															
19	Adjustment for changes in distr bution of risk pool membersh p by rating regions **															
20	Federal R sk Adjustment Program Impac (less than 1.00 to reflect a recovery															
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery															
22	Impact of adjustments due to experience period cla m data not being sufficiently credible															
23	Claim trend projection factor (midpo nt of exper ence period to mid point of rate applicabi ity period)															
24	Other 1 (specify)															
25	Other 2 (specify)															
26	Other 3 (specify)															
27	**Impact of Market Wide Adjustments (product L13 through L26)**				**1.391**	**1.391**	**1.391**	**1.391**	**1.391**	**1.391**	**1.391**	**1.391**	**1.391**	**1.391**	**1.391**	**1.391**
	** Not Included in Claim Trend Adjustment															
	Plan Level Adjustments															
28	Pricing actuarial value (without induced demand factor) #				0.848	0.848	0.848	0.848	0.848	0.848	0.848	0.848	0.848	0.848	0.848	0.848
29	Pricing actuarial value (only the induced demand factor) #				1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
30	Impact of provider network characteristics ##				1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
31	Impact of delivery system characteristics ##				1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of utilization management practices ##				1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Benefits in additional to EHB (greater than 1.00)				1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Administrative costs (excluding Exchange user fees and profits)				1.111	1.111	1.111	1.111	1.111	1.111	1.111	1.111	1.111	1.111	1.111	1.111
35	Profit/Contribution to surplus margins				1.021	1.021	1.021	1.021	1.021	1.021	1.021	1.021	1.021	1.021	1.021	1.021
36	Impact of eligibi ity categories (catastrophic plans only)				1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
37	Addition of Out of Network Benefit Option (e.g. POS or PPO if applicable				1.015	1.015	1.015	1.015	1.015	1.015	1.015	1.015	1.015	1.015	1.015	1.015
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY				1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Other 1 (specify)				1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Other 2 (specify)				1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**				**0.975**	**0.975**	**0.975**	**0.975**	**0.975**	**0.975**	**0.975**	**0.975**	**0.975**	**0.975**	**0.975**	**0.975**
	# Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupatio															
	## Beyond what is reflected in Market Wide adjustments															
42	**TOTAL PROJECTED INDEX RATE (L12 x L27 x L41)**				**545.46**	**545.46**	**545.46**	**545.46**	**545.46**	**545.46**	**545.46**	**545.46**	**545.46**	**545.46**	**545.46**	**545.46**

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

Company Name: Excellus Health Plan, Inc.
NAIC Code: 55107
SERFF Number: EXHP-128987637
Market Segment: ND

A. Complete a separate ROW for Metal Level/Exchange product in the current new On/Off Exchange product filing.
- Information should be for all the benefits included in that plan design (medical, drugs, etc).
- Enter the Metal Tier the On/Off Exchange product belongs to using the drop down menu, or enter a value.
- Enter the On/Off Designation using the drop down menu.
- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).
C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.
D. This form must be submitted as an Excel file and as a PDF file.

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	4.1 Period assumed - beginning date (MM/DD/YY)	4.2 Period assumed - ending date (MM/DD/YY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10
Platinum	Off Exchange	ExchangeBlue EPO Copay	01/01/14	12/31/14	7.70%	0.88%	0.20%	0.62%	0.00%	3.31%	4.65%	9.67%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	11.67%
Platinum	Off Exchange	ExchangeBlue EPO Copay	01/01/14	12/31/14	7.70%	0.88%	0.20%	0.62%	0.00%	3.31%	4.65%	9.67%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	11.67%
Platinum	Off Exchange	Excellus BCBS PPO Copay	01/01/14	12/31/14	7.70%	0.88%	0.20%	0.62%	0.00%	3.30%	4.59%	9.58%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	11.58%
Gold	Off Exchange	ExchangeBlue EPO Hybrid	01/01/14	12/31/14	7.70%	0.88%	0.23%	0.62%	0.00%	3.41%	5.13%	10.27%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	12.27%
Gold	Off Exchange	ExchangeBassett EPO	01/01/14	12/31/14	7.70%	0.88%	0.25%	0.62%	0.00%	3.54%	5.72%	11.01%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	13.01%
Silver	Off Exchange	ExchangeBlue EPO Hybrid	01/01/14	12/31/14	7.70%	0.88%	0.25%	0.62%	0.00%	3.54%	5.69%	10.98%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	12.98%
Silver	Off Exchange	ExchangeBlue EPO HDHP	01/01/14	12/31/14	7.70%	0.88%	0.34%	0.62%	0.00%	3.96%	7.66%	13.45%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	15.45%
Bronze	Off Exchange	ExchangeBlue EPO HDHP	01/01/14	12/31/14	7.70%	0.88%	0.42%	0.62%	0.00%	4.36%	9.47%	15.74%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	17.74%
Bronze	Off Exchange	ExchangeBlue EPO HDHP	01/01/14	12/31/14	7.70%	0.88%	0.42%	0.62%	0.00%	4.36%	9.47%	15.74%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	17.74%
Platinum	Off Exchange	Univera PPO Copay	01/01/14	12/31/14	7.70%	0.88%	0.20%	0.62%	0.00%	3.30%	4.60%	9.59%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	11.59%
Platinum	Off Exchange	Exchange Univera EPO Copay	01/01/14	12/31/14	7.70%	0.88%	0.20%	0.62%	0.00%	3.31%	4.67%	9.68%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	11.68%
Gold	Off Exchange	Exchange Univera EPO Hybrid	01/01/14	12/31/14	7.70%	0.88%	0.23%	0.62%	0.00%	3.42%	5.15%	10.29%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	12.29%
Silver	Off Exchange	Exchange Univera EPO Hybrid	01/01/14	12/31/14	7.70%	0.88%	0.25%	0.62%	0.00%	3.54%	5.71%	11.00%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	13.00%
Silver	Off Exchange	Exchange Univera EPO HDHP	01/01/14	12/31/14	7.70%	0.88%	0.34%	0.62%	0.00%	3.97%	7.68%	13.48%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	15.48%
Bronze	Off Exchange	Exchange Univera EPO HDHP	01/01/14	12/31/14	7.70%	0.88%	0.41%	0.62%	0.00%	4.35%	9.45%	15.71%	2.00%	0.00%	N/A	0.00%	N/A	0.00%	17.71%

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 $pmpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as $pmpm	12.3 Commissions and broker fees - as $pmpm	12.4 Premium Taxes - as $pmpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as $pmpm	12.6 Other administrative expenses - as $pmpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/ contribution to surplus) - as $pmpm	14. State income tax component - as $pmpm	15. Federal income tax component - as $pmpm	16. Reduction for assumed net investment income - as $pmpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
Platinum	Off Exchange	ExchangeBlue EPO Copay	4.73	1.10	3.32	0.00	17.77	24.99	51.90	10.74	0.00	0.00	0.00	62.64
Platinum	Off Exchange	ExchangeBlue EPO Copay	4.73	1.10	3.32	0.00	17.77	24.99	51.90	10.74	0.00	0.00	0.00	62.64
Platinum	Off Exchange	Excellus BCBS PPO Copay	4.95	1.13	3.47	0.00	18.52	25.78	53.84	11.24	0.00	0.00	0.00	65.08
Gold	Off Exchange	ExchangeBlue EPO Hybrid	4.28	1.09	3.00	0.00	16.56	24.91	49.83	9.70	0.00	0.00	0.00	59.54
Gold	Off Exchange	ExchangeBassett EPO	4.32	1.23	3.03	0.00	17.35	28.02	53.94	9.80	0.00	0.00	0.00	63.74
Silver	Off Exchange	ExchangeBlue EPO Hybrid	3.87	1.10	2.71	0.00	15.51	24.98	48.17	8.78	0.00	0.00	0.00	56.94
Silver	Off Exchange	ExchangeBlue EPO HDHP	2.90	1.11	2.03	0.00	13.03	25.19	44.25	6.58	0.00	0.00	0.00	50.83
Bronze	Off Exchange	ExchangeBlue EPO HDHP	2.34	1.10	1.64	0.00	11.55	25.13	41.76	5.31	0.00	0.00	0.00	47.07
Bronze	Off Exchange	ExchangeBlue EPO HDHP	2.34	1.10	1.64	0.00	11.55	25.13	41.76	5.31	0.00	0.00	0.00	47.07
Platinum	Off Exchange	Univera PPO Copay	5.22	1.19	3.66	0.00	19.53	27.22	56.82	11.84	0.00	0.00	0.00	68.66
Platinum	Off Exchange	Exchange Univera EPO Copay	5.14	1.19	3.60	0.00	19.33	27.22	56.49	11.67	0.00	0.00	0.00	68.16
Gold	Off Exchange	Exchange Univera EPO Hybrid	4.66	1.19	3.27	0.00	18.07	27.22	54.42	10.58	0.00	0.00	0.00	64.99
Silver	Off Exchange	Exchange Univera EPO Hybrid	4.20	1.19	2.94	0.00	16.87	27.22	52.43	9.53	0.00	0.00	0.00	61.97
Silver	Off Exchange	Exchange Univera EPO HDHP	3.12	1.19	2.19	0.00	14.06	27.22	47.78	7.09	0.00	0.00	0.00	54.87
Bronze	Off Exchange	Exchange Univera EPO HDHP	2.54	1.19	1.78	0.00	12.53	27.22	45.27	5.76	0.00	0.00	0.00	51.03