Filing at a Glance

Company:	Freelancers Health Service Corporation
Product Name:	FHSC IND OFF Exchange
State:	New York
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005C Individual - Other
Filing Type:	Off Exchange NG Forms & Rates
Date Submitted:	05/15/2013
SERFF Tr Num:	HNMN-129030684
SERFF Status:	Closed-APPR Approved
State Tr Num:	2013050117
State Status:	APPR Approved
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	09/27/2013
Disposition Status:	APPR Approved
Implementation Date:	09/27/2013

State Filing Description:

###Actuarial objection letter sent 6/3, response received 6/17, rates cleared to Legal 6/17. Legal objection letters sent 8/9, 8/27, 9/4, 9/13, and 9/16, awaiting company response to latest. Approved 9/27.

State: *New York* **Filing Company:** *Freelancers Health Service Corporation*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *FHSC IND OFF Exchange*
Project Name/Number: */*

General Information

Project Name:
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, Non Employer Group - Individual
Filing Status Changed: 09/27/2013
State Status Changed: 09/27/2013
Created By: [redacted]
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:
This filing contains policy forms and rates for products that will be offered outside of the New York Health Insurance Exchange.

Company and Contact

Filing Contact Information

[redacted]

Filing Company Information

(This filing was made by a third party - hinmanstraubpc)

Freelancers Health Service Corporation
112 West 34th Street
New York, NY 17058
[redacted]

CoCode: 0
Group Code:
Group Name:
FEIN Number: 45-3368051

State of Domicile: New York
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

State: *New York* **Filing Company:** *Freelancers Health Service Corporation*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *FHSC IND OFF Exchange*
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1. Is a parallel product being submitted for another issuing entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Commercial
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): No
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Form and Rate
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: No
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): No

State: *New York* **Filing Company:** *Freelancers Health Service Corporation*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *FHSC IND OFF Exchange*
Project Name/Number: */*

Rate Information

Rate data applies to filing.

Filing Method: Prior Review and Approval
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision: 05/14/2013
Filing Method of Last Filing: This is a new product that has not been previously reviewed.

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):
Freelancers Health Service Corporation	New Product	%	%				%	%

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

Rate Review Detail

COMPANY:

Company Name: Freelancers Health Service Corporation
HHS Issuer Id: 71644
Product Names: Individual Off-Exchange
Trend Factors:

FORMS:

New Policy Forms: FHSC-CAT001, FHSC-CHILD001, FHSC-IND002, FHSC-IND001, FHSC-WMBT001, FHSC-SB01, FHSC-SB02, FHSC-SB03, FHSC-SB04, FHSC-SB05, FHSC-SB06, FHSC-SB07, FHSC-SB08, FHSC-SB09, FHSC-SB10, FHSC-SB11, FHSC-SB12, FHSC-SB13, FHSC-SB14, FHSC-SB15, FHSC-SB16, FHSC-SB17, FHSC-SB18, FHSC-SB19, FHSC-20, FHSC-SB21, FHSC-SB22, FHSC-SB23
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 12
Benefit Change:
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

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

REQUESTED RATE:

Projected Earned Premium: 100.00
Projected Incurred Claims: 100.00
Annual $: Min: 100.00 Max: 100.00 Avg: 100.00

State: *New York* **Filing Company:** *Freelancers Health Service Corporation*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *FHSC IND OFF Exchange*
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Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Manual		New		FHSC Rate Manual (5-25-2013).pdf,

Freelancers Health Service Corporation
2014 Individual Rate Filing
Table of Contents

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

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Freelancers Health Service Corporation
2014 Individual Rate Filing
Rate Setting Parameters

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Index Rate (Adult)	214.578957
Conversion Factor	1.00

HIOS ID	Product	Market	Metal	Rate Factor
71644NY0010004	Essential Care Platinum	On and Off Exchange	Platinum	1.679497
71644NY0010003	Essential Care Gold	On and Off Exchange	Gold	1.428384
71644NY0010002	Essential Care Silver	On and Off Exchange	Silver	1.261463
71644NY0010001	Essential Care Bronze	On and Off Exchange	Bronze	1.000000
71644NY0010005	Essential Care Catastrophic	On and Off Exchange	Catastrophic	0.692666
71644NY0030004	Primary Select Platinum	On and Off Exchange	Platinum	1.610092
71644NY0030003	Primary Select Gold	On and Off Exchange	Gold	1.427252
71644NY0030002	Primary Select Silver	On and Off Exchange	Silver	1.260554
71644NY0040002	Primary Select Silver EPO	On and Off Exchange	Silver	1.189375
71644NY0030001	Primary Select Bronze	On and Off Exchange	Bronze	0.866851
71644NY0580004	EssentialCare Platinum Dental	On and Off Exchange	Platinum	1.703666
71644NY0580003	EssentialCare Gold Dental	On and Off Exchange	Gold	1.451964
71644NY0580002	EssentialCare Silver Dental	On and Off Exchange	Silver	1.284757
71644NY0580001	EssentialCare Bronze Dental	On and Off Exchange	Bronze	1.015137
71644NY0580005	EssentialCare Catastrophic Dental	On and Off Exchange	Catastrophic	0.697881
71644NY0600004	PrimarySelect Platinum Dental	On and Off Exchange	Platinum	1.634260
71644NY0600003	PrimarySelect Gold Dental	On and Off Exchange	Gold	1.450832
71644NY0600002	PrimarySelect Silver Dental	On and Off Exchange	Silver	1.283848
71644NY0610002	PrimarySelect Silver EPO Dental	On and Off Exchange	Silver	1.212669
71644NY0600001	PrimarySelect Bronze Dental	On and Off Exchange	Bronze	0.881988
71644NY0020004	Essential Care Platinum Child-Only	On and Off Exchange	Platinum	0.691953
71644NY0020003	Essential Care Gold Child-Only	On and Off Exchange	Gold	0.588494
71644NY0020002	Essential Care Silver Child-Only	On and Off Exchange	Silver	0.519723
71644NY0020001	Essential Care Bronze Child-Only	On and Off Exchange	Bronze	0.412000
71644NY0590004	EssentialCare Platinum Dental Child-Only	On and Off Exchange	Platinum	0.701910
71644NY0590003	EssentialCare Gold Dental Child-Only	On and Off Exchange	Gold	0.598209
71644NY0590002	EssentialCare Silver Dental Child-Only	On and Off Exchange	Silver	0.529320
71644NY0590001	EssentialCare Bronze Dental Child-Only	On and Off Exchange	Bronze	0.418236
71644NY0090004	Essential Care Platinum Age 29 Option	On and Off Exchange	Platinum	1.679497
71644NY0090003	Essential Care Gold Age 29 Option	On and Off Exchange	Gold	1.428384
71644NY0090002	Essential Care Silver Age 29 Option	On and Off Exchange	Silver	1.261463
71644NY0090001	Essential Care Bronze Age 29 Option	On and Off Exchange	Bronze	1.000000
71644NY0100004	EssentialCare Platinum Dental Age 29 Option	On and Off Exchange	Platinum	1.703666
71644NY0100003	EssentialCare Gold Dental Age 29 Option	On and Off Exchange	Gold	1.451964
71644NY0100002	EssentialCare Silver Dental Age 29 Option	On and Off Exchange	Silver	1.284757
71644NY0100001	EssentialCare Bronze Dental Age 29 Option	On and Off Exchange	Bronze	1.015137
71644NY0130004	Primary Select Platinum Age 29 Option	On and Off Exchange	Platinum	1.610092
71644NY0130003	Primary Select Gold Age 29 Option	On and Off Exchange	Gold	1.427252
71644NY0130002	Primary Select Silver Age 29 Option	On and Off Exchange	Silver	1.260554
71644NY0150002	Primary Select Silver EPO Age 29 Option	On and Off Exchange	Silver	1.189375
71644NY0130001	Primary Select Bronze Age 29 Option	On and Off Exchange	Bronze	0.866851
71644NY0140004	PrimarySelect Platinum Dental Age 29 Option	On and Off Exchange	Platinum	1.634260
71644NY0140003	PrimarySelect Gold Dental Age 29 Option	On and Off Exchange	Gold	1.450832
71644NY0140002	PrimarySelect Silver Dental Age 29 Option	On and Off Exchange	Silver	1.283848
71644NY0160002	PrimarySelect Silver EPO Dental Age 29 Option	On and Off Exchange	Silver	1.212669
71644NY0140001	PrimarySelect Bronze Dental Age 29 Option	On and Off Exchange	Bronze	0.881988

Age Band	Rate Factor	Tobacco Factor
0-17	1.000	1.000
18	1.000	1.000
19	1.000	1.000
20	1.000	1.000
21	1.000	1.000
22	1.000	1.000
23	1.000	1.000
24	1.000	1.000
25	1.000	1.000
26	1.000	1.000
27	1.000	1.000
28	1.000	1.000
29	1.000	1.000
30	1.000	1.000
31	1.000	1.000
32	1.000	1.000
33	1.000	1.000
34	1.000	1.000
35	1.000	1.000
36	1.000	1.000
37	1.000	1.000
38	1.000	1.000
39	1.000	1.000
40	1.000	1.000
41	1.000	1.000
42	1.000	1.000
43	1.000	1.000
44	1.000	1.000
45	1.000	1.000
46	1.000	1.000
47	1.000	1.000
48	1.000	1.000
49	1.000	1.000
50	1.000	1.000
51	1.000	1.000
52	1.000	1.000
53	1.000	1.000
54	1.000	1.000
55	1.000	1.000
56	1.000	1.000
57	1.000	1.000
58	1.000	1.000
59	1.000	1.000
60	1.000	1.000
61	1.000	1.000
62	1.000	1.000
63	1.000	1.000
64+	1.000	1.000

Geographic Factors:

Area	Rate Factor
Region 1	1.086664
Region 2	1.017235
Region 3	1.220650
Region 4	1.431276
Region 5	1.000000
Region 6	1.056058
Region 7	1.027582
Region 8	1.431276

Four Tier Family Factors:

Individual	1.000
Couple	2.000
Primary Subscriber and One Dependent	1.700
Primary Subscriber and Two Dependents	1.700
Primary Subscriber and Three or More Dependents	1.700
Couple and One Dependent	2.850
Couple and Two Dependents	2.850
Couple and Three or More Dependents	2.850

Sample Rate Calculation:
Platinum Select in Region 2 for a Couple with Two Depedents =
Base Rate x Conversion Factor x Platinum Select Factor x Region 2 Factor x Couple and Two Dependents Factor =
$214.58 x 1.00 x 1.610092 x 1.017235 x 2.85 = $1,001.62

Freelancers Health Service Corporation
2014 Individual Rate Filing
Rates

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

		Individual	Couple	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Couple and One Dependent	Couple and Two Dependents	Couple and Three or More Dependents
Essential Care Platinum	Region 1	$391.62	$783.23	$665.75	$665.75	$665.75	$1,116.11	$1,116.11	$1,116.11
	Region 2	$366.60	$733.19	$623.21	$623.21	$623.21	$1,044.80	$1,044.80	$1,044.80
	Region 3	$439.90	$879.81	$747.84	$747.84	$747.84	$1,253.73	$1,253.73	$1,253.73
	Region 4	$515.81	$1,031.62	$876.88	$876.88	$876.88	$1,470.06	$1,470.06	$1,470.06
	Region 5	$360.38	$720.77	$612.65	$612.65	$612.65	$1,027.10	$1,027.10	$1,027.10
	Region 6	$380.59	$761.17	$647.00	$647.00	$647.00	$1,084.67	$1,084.67	$1,084.67
	Region 7	$370.32	$740.65	$629.55	$629.55	$629.55	$1,055.43	$1,055.43	$1,055.43
	Region 8	$515.81	$1,031.62	$876.88	$876.88	$876.88	$1,470.06	$1,470.06	$1,470.06
Essential Care Gold	Region 1	$333.06	$666.13	$566.21	$566.21	$566.21	$949.23	$949.23	$949.23
	Region 2	$311.78	$623.57	$530.03	$530.03	$530.03	$888.58	$888.58	$888.58
	Region 3	$374.13	$748.26	$636.02	$636.02	$636.02	$1,066.27	$1,066.27	$1,066.27
	Region 4	$438.69	$877.38	$745.77	$745.77	$745.77	$1,250.26	$1,250.26	$1,250.26
	Region 5	$306.50	$613.00	$521.05	$521.05	$521.05	$873.53	$873.53	$873.53
	Region 6	$323.68	$647.37	$550.26	$550.26	$550.26	$922.50	$922.50	$922.50
	Region 7	$314.96	$629.91	$535.42	$535.42	$535.42	$897.62	$897.62	$897.62
	Region 8	$438.69	$877.38	$745.77	$745.77	$745.77	$1,250.26	$1,250.26	$1,250.26
Essential Care Silver	Region 1	$294.14	$588.28	$500.04	$500.04	$500.04	$838.30	$838.30	$838.30
	Region 2	$275.35	$550.70	$468.09	$468.09	$468.09	$784.74	$784.74	$784.74
	Region 3	$330.41	$660.82	$561.70	$561.70	$561.70	$941.67	$941.67	$941.67
	Region 4	$387.42	$774.85	$658.62	$658.62	$658.62	$1,104.15	$1,104.15	$1,104.15
	Region 5	$270.68	$541.37	$460.16	$460.16	$460.16	$771.45	$771.45	$771.45
	Region 6	$285.86	$571.71	$485.96	$485.96	$485.96	$814.69	$814.69	$814.69
	Region 7	$278.15	$556.30	$472.85	$472.85	$472.85	$792.73	$792.73	$792.73
	Region 8	$387.42	$774.85	$658.62	$658.62	$658.62	$1,104.15	$1,104.15	$1,104.15
Essential Care Bronze	Region 1	$233.18	$466.35	$396.40	$396.40	$396.40	$664.55	$664.55	$664.55
	Region 2	$218.28	$436.55	$371.07	$371.07	$371.07	$622.09	$622.09	$622.09
	Region 3	$261.93	$523.85	$445.27	$445.27	$445.27	$746.49	$746.49	$746.49
	Region 4	$307.12	$614.24	$522.11	$522.11	$522.11	$875.30	$875.30	$875.30
	Region 5	$214.58	$429.16	$364.78	$364.78	$364.78	$611.55	$611.55	$611.55
	Region 6	$226.61	$453.22	$385.23	$385.23	$385.23	$645.83	$645.83	$645.83
	Region 7	$220.50	$441.00	$374.85	$374.85	$374.85	$628.42	$628.42	$628.42
	Region 8	$307.12	$614.24	$522.11	$522.11	$522.11	$875.30	$875.30	$875.30
Essential Care Catastrophic	Region 1	$161.51	$323.02	$274.57	$274.57	$274.57	$460.31	$460.31	$460.31
	Region 2	$151.19	$302.39	$257.03	$257.03	$257.03	$430.90	$430.90	$430.90
	Region 3	$181.43	$362.85	$308.43	$308.43	$308.43	$517.07	$517.07	$517.07
	Region 4	$212.73	$425.47	$361.65	$361.65	$361.65	$606.29	$606.29	$606.29
	Region 5	$148.63	$297.26	$252.67	$252.67	$252.67	$423.60	$423.60	$423.60
	Region 6	$156.96	$313.93	$266.84	$266.84	$266.84	$447.35	$447.35	$447.35
	Region 7	$152.73	$305.46	$259.64	$259.64	$259.64	$435.28	$435.28	$435.28
	Region 8	$212.73	$425.47	$361.65	$361.65	$361.65	$606.29	$606.29	$606.29
Primary Select Platinum	Region 1	$375.43	$750.87	$638.24	$638.24	$638.24	$1,069.99	$1,069.99	$1,069.99
	Region 2	$351.45	$702.89	$597.46	$597.46	$597.46	$1,001.62	$1,001.62	$1,001.62
	Region 3	$421.72	$843.45	$716.93	$716.93	$716.93	$1,201.92	$1,201.92	$1,201.92
	Region 4	$494.49	$988.99	$840.64	$840.64	$840.64	$1,409.31	$1,409.31	$1,409.31
	Region 5	$345.49	$690.98	$587.34	$587.34	$587.34	$984.65	$984.65	$984.65
	Region 6	$364.86	$729.72	$620.26	$620.26	$620.26	$1,039.85	$1,039.85	$1,039.85
	Region 7	$355.02	$710.04	$603.54	$603.54	$603.54	$1,011.81	$1,011.81	$1,011.81
	Region 8	$494.49	$988.99	$840.64	$840.64	$840.64	$1,409.31	$1,409.31	$1,409.31
Primary Select Gold	Region 1	$332.80	$665.60	$565.76	$565.76	$565.76	$948.48	$948.48	$948.48
	Region 2	$311.54	$623.07	$529.61	$529.61	$529.61	$887.88	$887.88	$887.88
	Region 3	$373.83	$747.67	$635.52	$635.52	$635.52	$1,065.43	$1,065.43	$1,065.43
	Region 4	$438.34	$876.68	$745.18	$745.18	$745.18	$1,249.27	$1,249.27	$1,249.27
	Region 5	$306.26	$612.52	$520.64	$520.64	$520.64	$872.84	$872.84	$872.84
	Region 6	$323.43	$646.85	$549.83	$549.83	$549.83	$921.77	$921.77	$921.77
	Region 7	$314.71	$629.41	$535.00	$535.00	$535.00	$896.91	$896.91	$896.91
	Region 8	$438.34	$876.68	$745.18	$745.18	$745.18	$1,249.27	$1,249.27	$1,249.27
Primary Select Silver	Region 1	$293.93	$587.86	$499.68	$499.68	$499.68	$837.70	$837.70	$837.70
	Region 2	$275.15	$550.30	$467.76	$467.76	$467.76	$784.18	$784.18	$784.18
	Region 3	$330.17	$660.34	$561.29	$561.29	$561.29	$940.99	$940.99	$940.99
	Region 4	$387.14	$774.29	$658.14	$658.14	$658.14	$1,103.36	$1,103.36	$1,103.36
	Region 5	$270.49	$540.98	$459.83	$459.83	$459.83	$770.89	$770.89	$770.89
	Region 6	$285.65	$571.30	$485.61	$485.61	$485.61	$814.11	$814.11	$814.11
	Region 7	$277.95	$555.90	$472.51	$472.51	$472.51	$792.15	$792.15	$792.15
	Region 8	$387.14	$774.29	$658.14	$658.14	$658.14	$1,103.36	$1,103.36	$1,103.36
Primary Select Silver EPO	Region 1	$277.33	$554.67	$471.47	$471.47	$471.47	$790.40	$790.40	$790.40
	Region 2	$259.61	$519.23	$441.34	$441.34	$441.34	$739.90	$739.90	$739.90
	Region 3	$311.53	$623.06	$529.60	$529.60	$529.60	$887.86	$887.86	$887.86
	Region 4	$365.28	$730.57	$620.98	$620.98	$620.98	$1,041.06	$1,041.06	$1,041.06
	Region 5	$255.21	$510.43	$433.87	$433.87	$433.87	$727.36	$727.36	$727.36
	Region 6	$269.52	$539.04	$458.19	$458.19	$458.19	$768.14	$768.14	$768.14
	Region 7	$262.25	$524.51	$445.83	$445.83	$445.83	$747.42	$747.42	$747.42
	Region 8	$365.28	$730.57	$620.98	$620.98	$620.98	$1,041.06	$1,041.06	$1,041.06
Primary Select Bronze	Region 1	$202.13	$404.26	$343.62	$343.62	$343.62	$576.07	$576.07	$576.07
	Region 2	$189.21	$378.43	$321.66	$321.66	$321.66	$539.26	$539.26	$539.26
	Region 3	$227.05	$454.10	$385.99	$385.99	$385.99	$647.09	$647.09	$647.09
	Region 4	$266.23	$532.46	$452.59	$452.59	$452.59	$758.75	$758.75	$758.75
	Region 5	$186.01	$372.02	$316.21	$316.21	$316.21	$530.12	$530.12	$530.12
	Region 6	$196.44	$392.87	$333.94	$333.94	$333.94	$559.84	$559.84	$559.84
	Region 7	$191.14	$382.28	$324.94	$324.94	$324.94	$544.74	$544.74	$544.74
	Region 8	$266.23	$532.46	$452.59	$452.59	$452.59	$758.75	$758.75	$758.75
EssentialCare Platinum Dental	Region 1	$397.25	$794.51	$675.33	$675.33	$675.33	$1,132.17	$1,132.17	$1,132.17
	Region 2	$371.87	$743.74	$632.18	$632.18	$632.18	$1,059.83	$1,059.83	$1,059.83
	Region 3	$446.23	$892.47	$758.60	$758.60	$758.60	$1,271.77	$1,271.77	$1,271.77
	Region 4	$523.23	$1,046.47	$889.50	$889.50	$889.50	$1,491.21	$1,491.21	$1,491.21
	Region 5	$365.57	$731.14	$621.47	$621.47	$621.47	$1,041.88	$1,041.88	$1,041.88
	Region 6	$386.06	$772.13	$656.31	$656.31	$656.31	$1,100.28	$1,100.28	$1,100.28
	Region 7	$375.65	$751.31	$638.61	$638.61	$638.61	$1,070.61	$1,070.61	$1,070.61
	Region 8	$523.23	$1,046.47	$889.50	$889.50	$889.50	$1,491.21	$1,491.21	$1,491.21
EssentialCare Gold Dental	Region 1	$338.56	$677.12	$575.56	$575.56	$575.56	$964.90	$964.90	$964.90
	Region 2	$316.93	$633.86	$538.78	$538.78	$538.78	$903.25	$903.25	$903.25
	Region 3	$380.31	$760.61	$646.52	$646.52	$646.52	$1,083.87	$1,083.87	$1,083.87
	Region 4	$445.93	$891.86	$758.08	$758.08	$758.08	$1,270.90	$1,270.90	$1,270.90
	Region 5	$311.56	$623.12	$529.65	$529.65	$529.65	$887.95	$887.95	$887.95
	Region 6	$329.03	$658.05	$559.34	$559.34	$559.34	$937.73	$937.73	$937.73
	Region 7	$320.15	$640.31	$544.26	$544.26	$544.26	$912.44	$912.44	$912.44
	Region 8	$445.93	$891.86	$758.08	$758.08	$758.08	$1,270.90	$1,270.90	$1,270.90
EssentialCare Silver Dental	Region 1	$299.57	$599.15	$509.27	$509.27	$509.27	$853.78	$853.78	$853.78
	Region 2	$280.43	$560.87	$476.74	$476.74	$476.74	$799.23	$799.23	$799.23
	Region 3	$336.51	$673.02	$572.07	$572.07	$572.07	$959.06	$959.06	$959.06
	Region 4	$394.58	$789.15	$670.78	$670.78	$670.78	$1,124.54	$1,124.54	$1,124.54
	Region 5	$275.68	$551.36	$468.66	$468.66	$468.66	$785.69	$785.69	$785.69
	Region 6	$291.14	$582.27	$494.93	$494.93	$494.93	$829.74	$829.74	$829.74
	Region 7	$283.29	$566.57	$481.59	$481.59	$481.59	$807.36	$807.36	$807.36
	Region 8	$394.58	$789.15	$670.78	$670.78	$670.78	$1,124.54	$1,124.54	$1,124.54
EssentialCare Bronze Dental	Region 1	$236.70	$473.41	$402.40	$402.40	$402.40	$674.61	$674.61	$674.61
	Region 2	$221.58	$443.16	$376.69	$376.69	$376.69	$631.51	$631.51	$631.51
	Region 3	$265.89	$531.78	$452.01	$452.01	$452.01	$757.79	$757.79	$757.79
	Region 4	$311.77	$623.54	$530.01	$530.01	$530.01	$888.55	$888.55	$888.55
	Region 5	$217.83	$435.65	$370.31	$370.31	$370.31	$620.81	$620.81	$620.81
	Region 6	$230.04	$460.08	$391.06	$391.06	$391.06	$655.61	$655.61	$655.61
	Region 7	$223.84	$447.67	$380.52	$380.52	$380.52	$637.93	$637.93	$637.93
	Region 8	$311.77	$623.54	$530.01	$530.01	$530.01	$888.55	$888.55	$888.55
EssentialCare Catastrophic Dental	Region 1	$162.73	$325.46	$276.64	$276.64	$276.64	$463.78	$463.78	$463.78
	Region 2	$152.33	$304.66	$258.96	$258.96	$258.96	$434.14	$434.14	$434.14
	Region 3	$182.79	$365.59	$310.75	$310.75	$310.75	$520.96	$520.96	$520.96
	Region 4	$214.33	$428.67	$364.37	$364.37	$364.37	$610.85	$610.85	$610.85
	Region 5	$149.75	$299.50	$254.58	$254.58	$254.58	$426.79	$426.79	$426.79
	Region 6	$158.15	$316.29	$268.85	$268.85	$268.85	$450.71	$450.71	$450.71
	Region 7	$153.88	$307.76	$261.60	$261.60	$261.60	$438.56	$438.56	$438.56
	Region 8	$214.33	$428.67	$364.37	$364.37	$364.37	$610.85	$610.85	$610.85

Freelancers Health Service Corporation
2014 Individual Rate Filing
Rates

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

		Individual	Couple	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Couple and One Dependent	Couple and Two Dependents	Couple and Three or More Dependents
PrimarySelect Platinum Dental	Region 1	$381.07	$762.14	$647.82	$647.82	$647.82	$1,086.05	$1,086.05	$1,086.05
	Region 2	$356.72	$713.44	$606.43	$606.43	$606.43	$1,016.66	$1,016.66	$1,016.66
	Region 3	$428.05	$856.11	$727.69	$727.69	$727.69	$1,219.96	$1,219.96	$1,219.96
	Region 4	$501.92	$1,003.83	$853.26	$853.26	$853.26	$1,430.46	$1,430.46	$1,430.46
	Region 5	$350.68	$701.36	$596.15	$596.15	$596.15	$999.43	$999.43	$999.43
	Region 6	$370.34	$740.67	$629.57	$629.57	$629.57	$1,055.46	$1,055.46	$1,055.46
	Region 7	$360.35	$720.70	$612.60	$612.60	$612.60	$1,027.00	$1,027.00	$1,027.00
	Region 8	$501.92	$1,003.83	$853.26	$853.26	$853.26	$1,430.46	$1,430.46	$1,430.46
PrimarySelect Gold Dental	Region 1	$338.30	$676.60	$575.11	$575.11	$575.11	$964.15	$964.15	$964.15
	Region 2	$316.68	$633.37	$538.36	$538.36	$538.36	$902.55	$902.55	$902.55
	Region 3	$380.01	$760.02	$646.02	$646.02	$646.02	$1,083.03	$1,083.03	$1,083.03
	Region 4	$445.58	$891.16	$757.49	$757.49	$757.49	$1,269.91	$1,269.91	$1,269.91
	Region 5	$311.32	$622.64	$529.24	$529.24	$529.24	$887.26	$887.26	$887.26
	Region 6	$328.77	$657.54	$558.91	$558.91	$558.91	$936.99	$936.99	$936.99
	Region 7	$319.90	$639.81	$543.84	$543.84	$543.84	$911.73	$911.73	$911.73
	Region 8	$445.58	$891.16	$757.49	$757.49	$757.49	$1,269.91	$1,269.91	$1,269.91
PrimarySelect Silver Dental	Region 1	$299.36	$598.72	$508.91	$508.91	$508.91	$853.18	$853.18	$853.18
	Region 2	$280.23	$560.47	$476.40	$476.40	$476.40	$798.67	$798.67	$798.67
	Region 3	$336.27	$672.55	$571.66	$571.66	$571.66	$958.38	$958.38	$958.38
	Region 4	$394.30	$788.60	$670.31	$670.31	$670.31	$1,123.75	$1,123.75	$1,123.75
	Region 5	$275.49	$550.97	$468.33	$468.33	$468.33	$785.14	$785.14	$785.14
	Region 6	$290.93	$581.86	$494.58	$494.58	$494.58	$829.15	$829.15	$829.15
	Region 7	$283.09	$566.17	$481.24	$481.24	$481.24	$806.79	$806.79	$806.79
	Region 8	$394.30	$788.60	$670.31	$670.31	$670.31	$1,123.75	$1,123.75	$1,123.75
PrimarySelect Silver EPO Dental	Region 1	$282.76	$565.53	$480.70	$480.70	$480.70	$805.88	$805.88	$805.88
	Region 2	$264.70	$529.40	$449.99	$449.99	$449.99	$754.39	$754.39	$754.39
	Region 3	$317.63	$635.26	$539.97	$539.97	$539.97	$905.24	$905.24	$905.24
	Region 4	$372.44	$744.87	$633.14	$633.14	$633.14	$1,061.45	$1,061.45	$1,061.45
	Region 5	$260.21	$520.43	$442.36	$442.36	$442.36	$741.61	$741.61	$741.61
	Region 6	$274.80	$549.60	$467.16	$467.16	$467.16	$783.18	$783.18	$783.18
	Region 7	$267.39	$534.78	$454.56	$454.56	$454.56	$762.06	$762.06	$762.06
	Region 8	$372.44	$744.87	$633.14	$633.14	$633.14	$1,061.45	$1,061.45	$1,061.45
PrimarySelect Bronze Dental	Region 1	$205.66	$411.32	$349.62	$349.62	$349.62	$586.12	$586.12	$586.12
	Region 2	$192.52	$385.04	$327.28	$327.28	$327.28	$548.68	$548.68	$548.68
	Region 3	$231.02	$462.03	$392.73	$392.73	$392.73	$658.39	$658.39	$658.39
	Region 4	$270.88	$541.76	$460.49	$460.49	$460.49	$772.00	$772.00	$772.00
	Region 5	$189.26	$378.51	$321.74	$321.74	$321.74	$539.38	$539.38	$539.38
	Region 6	$199.87	$399.73	$339.77	$339.77	$339.77	$569.62	$569.62	$569.62
	Region 7	$194.48	$388.95	$330.61	$330.61	$330.61	$554.26	$554.26	$554.26
	Region 8	$270.88	$541.76	$460.49	$460.49	$460.49	$772.00	$772.00	$772.00
Essential Care Platinum Child-Only	Region 1	$161.35	$161.35	$161.35	$161.35	$161.35	$161.35	$161.35	$161.35
	Region 2	$151.04	$151.04	$151.04	$151.04	$151.04	$151.04	$151.04	$151.04
	Region 3	$181.24	$181.24	$181.24	$181.24	$181.24	$181.24	$181.24	$181.24
	Region 4	$212.51	$212.51	$212.51	$212.51	$212.51	$212.51	$212.51	$212.51
	Region 5	$148.48	$148.48	$148.48	$148.48	$148.48	$148.48	$148.48	$148.48
	Region 6	$156.80	$156.80	$156.80	$156.80	$156.80	$156.80	$156.80	$156.80
	Region 7	$152.57	$152.57	$152.57	$152.57	$152.57	$152.57	$152.57	$152.57
	Region 8	$212.51	$212.51	$212.51	$212.51	$212.51	$212.51	$212.51	$212.51
Essential Care Gold Child-Only	Region 1	$137.22	$137.22	$137.22	$137.22	$137.22	$137.22	$137.22	$137.22
	Region 2	$128.45	$128.45	$128.45	$128.45	$128.45	$128.45	$128.45	$128.45
	Region 3	$154.14	$154.14	$154.14	$154.14	$154.14	$154.14	$154.14	$154.14
	Region 4	$180.74	$180.74	$180.74	$180.74	$180.74	$180.74	$180.74	$180.74
	Region 5	$126.28	$126.28	$126.28	$126.28	$126.28	$126.28	$126.28	$126.28
	Region 6	$133.36	$133.36	$133.36	$133.36	$133.36	$133.36	$133.36	$133.36
	Region 7	$129.76	$129.76	$129.76	$129.76	$129.76	$129.76	$129.76	$129.76
	Region 8	$180.74	$180.74	$180.74	$180.74	$180.74	$180.74	$180.74	$180.74
Essential Care Silver Child-Only	Region 1	$121.19	$121.19	$121.19	$121.19	$121.19	$121.19	$121.19	$121.19
	Region 2	$113.44	$113.44	$113.44	$113.44	$113.44	$113.44	$113.44	$113.44
	Region 3	$136.13	$136.13	$136.13	$136.13	$136.13	$136.13	$136.13	$136.13
	Region 4	$159.62	$159.62	$159.62	$159.62	$159.62	$159.62	$159.62	$159.62
	Region 5	$111.52	$111.52	$111.52	$111.52	$111.52	$111.52	$111.52	$111.52
	Region 6	$117.77	$117.77	$117.77	$117.77	$117.77	$117.77	$117.77	$117.77
	Region 7	$114.60	$114.60	$114.60	$114.60	$114.60	$114.60	$114.60	$114.60
	Region 8	$159.62	$159.62	$159.62	$159.62	$159.62	$159.62	$159.62	$159.62
Essential Care Bronze Child-Only	Region 1	$96.07	$96.07	$96.07	$96.07	$96.07	$96.07	$96.07	$96.07
	Region 2	$89.93	$89.93	$89.93	$89.93	$89.93	$89.93	$89.93	$89.93
	Region 3	$107.91	$107.91	$107.91	$107.91	$107.91	$107.91	$107.91	$107.91
	Region 4	$126.53	$126.53	$126.53	$126.53	$126.53	$126.53	$126.53	$126.53
	Region 5	$88.41	$88.41	$88.41	$88.41	$88.41	$88.41	$88.41	$88.41
	Region 6	$93.36	$93.36	$93.36	$93.36	$93.36	$93.36	$93.36	$93.36
	Region 7	$90.84	$90.84	$90.84	$90.84	$90.84	$90.84	$90.84	$90.84
	Region 8	$126.53	$126.53	$126.53	$126.53	$126.53	$126.53	$126.53	$126.53
EssentialCare Platinum Dental Child-Only	Region 1	$163.67	$163.67	$163.67	$163.67	$163.67	$163.67	$163.67	$163.67
	Region 2	$153.21	$153.21	$153.21	$153.21	$153.21	$153.21	$153.21	$153.21
	Region 3	$183.85	$183.85	$183.85	$183.85	$183.85	$183.85	$183.85	$183.85
	Region 4	$215.57	$215.57	$215.57	$215.57	$215.57	$215.57	$215.57	$215.57
	Region 5	$150.62	$150.62	$150.62	$150.62	$150.62	$150.62	$150.62	$150.62
	Region 6	$159.06	$159.06	$159.06	$159.06	$159.06	$159.06	$159.06	$159.06
	Region 7	$154.77	$154.77	$154.77	$154.77	$154.77	$154.77	$154.77	$154.77
	Region 8	$215.57	$215.57	$215.57	$215.57	$215.57	$215.57	$215.57	$215.57
EssentialCare Gold Dental Child-Only	Region 1	$139.49	$139.49	$139.49	$139.49	$139.49	$139.49	$139.49	$139.49
	Region 2	$130.58	$130.58	$130.58	$130.58	$130.58	$130.58	$130.58	$130.58
	Region 3	$156.69	$156.69	$156.69	$156.69	$156.69	$156.69	$156.69	$156.69
	Region 4	$183.72	$183.72	$183.72	$183.72	$183.72	$183.72	$183.72	$183.72
	Region 5	$128.36	$128.36	$128.36	$128.36	$128.36	$128.36	$128.36	$128.36
	Region 6	$135.56	$135.56	$135.56	$135.56	$135.56	$135.56	$135.56	$135.56
	Region 7	$131.90	$131.90	$131.90	$131.90	$131.90	$131.90	$131.90	$131.90
	Region 8	$183.72	$183.72	$183.72	$183.72	$183.72	$183.72	$183.72	$183.72
EssentialCare Silver Dental Child-Only	Region 1	$123.42	$123.42	$123.42	$123.42	$123.42	$123.42	$123.42	$123.42
	Region 2	$115.54	$115.54	$115.54	$115.54	$115.54	$115.54	$115.54	$115.54
	Region 3	$138.64	$138.64	$138.64	$138.64	$138.64	$138.64	$138.64	$138.64
	Region 4	$162.57	$162.57	$162.57	$162.57	$162.57	$162.57	$162.57	$162.57
	Region 5	$113.58	$113.58	$113.58	$113.58	$113.58	$113.58	$113.58	$113.58
	Region 6	$119.95	$119.95	$119.95	$119.95	$119.95	$119.95	$119.95	$119.95
	Region 7	$116.71	$116.71	$116.71	$116.71	$116.71	$116.71	$116.71	$116.71
	Region 8	$162.57	$162.57	$162.57	$162.57	$162.57	$162.57	$162.57	$162.57
EssentialCare Bronze Dental Child-Only	Region 1	$97.52	$97.52	$97.52	$97.52	$97.52	$97.52	$97.52	$97.52
	Region 2	$91.29	$91.29	$91.29	$91.29	$91.29	$91.29	$91.29	$91.29
	Region 3	$109.55	$109.55	$109.55	$109.55	$109.55	$109.55	$109.55	$109.55
	Region 4	$128.45	$128.45	$128.45	$128.45	$128.45	$128.45	$128.45	$128.45
	Region 5	$89.74	$89.74	$89.74	$89.74	$89.74	$89.74	$89.74	$89.74
	Region 6	$94.78	$94.78	$94.78	$94.78	$94.78	$94.78	$94.78	$94.78
	Region 7	$92.22	$92.22	$92.22	$92.22	$92.22	$92.22	$92.22	$92.22
	Region 8	$128.45	$128.45	$128.45	$128.45	$128.45	$128.45	$128.45	$128.45
Essential Care Platinum Age 29 Option	Region 1	$391.62	$783.23	$665.75	$665.75	$665.75	$1,116.11	$1,116.11	$1,116.11
	Region 2	$366.60	$733.19	$623.21	$623.21	$623.21	$1,044.80	$1,044.80	$1,044.80
	Region 3	$439.90	$879.81	$747.84	$747.84	$747.84	$1,253.73	$1,253.73	$1,253.73
	Region 4	$515.81	$1,031.62	$876.88	$876.88	$876.88	$1,470.06	$1,470.06	$1,470.06
	Region 5	$360.38	$720.77	$612.65	$612.65	$612.65	$1,027.10	$1,027.10	$1,027.10
	Region 6	$380.59	$761.17	$647.00	$647.00	$647.00	$1,084.67	$1,084.67	$1,084.67
	Region 7	$370.32	$740.65	$629.55	$629.55	$629.55	$1,055.43	$1,055.43	$1,055.43
	Region 8	$515.81	$1,031.62	$876.88	$876.88	$876.88	$1,470.06	$1,470.06	$1,470.06
Essential Care Gold Age 29 Option	Region 1	$333.06	$666.13	$566.21	$566.21	$566.21	$949.23	$949.23	$949.23
	Region 2	$311.78	$623.57	$530.03	$530.03	$530.03	$888.58	$888.58	$888.58
	Region 3	$374.13	$748.26	$636.02	$636.02	$636.02	$1,066.27	$1,066.27	$1,066.27
	Region 4	$438.69	$877.38	$745.77	$745.77	$745.77	$1,250.26	$1,250.26	$1,250.26
	Region 5	$306.50	$613.00	$521.05	$521.05	$521.05	$873.53	$873.53	$873.53
	Region 6	$323.68	$647.37	$550.26	$550.26	$550.26	$922.50	$922.50	$922.50
	Region 7	$314.96	$629.91	$535.42	$535.42	$535.42	$897.62	$897.62	$897.62
	Region 8	$438.69	$877.38	$745.77	$745.77	$745.77	$1,250.26	$1,250.26	$1,250.26

Freelancers Health Service Corporation
2014 Individual Rate Filing
Rates

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

		Individual	Couple	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Couple and One Dependent	Couple and Two Dependents	Couple and Three or More Dependents
Essential Care Silver	Region 1	$294.14	$588.28	$500.04	$500.04	$500.04	$838.30	$838.30	$838.30
Age 29 Option	Region 2	$275.35	$550.70	$468.09	$468.09	$468.09	$784.74	$784.74	$784.74
	Region 3	$330.41	$660.82	$561.70	$561.70	$561.70	$941.67	$941.67	$941.67
	Region 4	$387.42	$774.85	$658.62	$658.62	$658.62	$1,104.15	$1,104.15	$1,104.15
	Region 5	$270.68	$541.37	$460.16	$460.16	$460.16	$771.45	$771.45	$771.45
	Region 6	$285.86	$571.71	$485.96	$485.96	$485.96	$814.69	$814.69	$814.69
	Region 7	$278.15	$556.30	$472.85	$472.85	$472.85	$792.73	$792.73	$792.73
	Region 8	$387.42	$774.85	$658.62	$658.62	$658.62	$1,104.15	$1,104.15	$1,104.15
Essential Care Bronze	Region 1	$233.18	$466.35	$396.40	$396.40	$396.40	$664.55	$664.55	$664.55
Age 29 Option	Region 2	$218.28	$436.55	$371.07	$371.07	$371.07	$622.09	$622.09	$622.09
	Region 3	$261.93	$523.85	$445.27	$445.27	$445.27	$746.49	$746.49	$746.49
	Region 4	$307.12	$614.24	$522.11	$522.11	$522.11	$875.30	$875.30	$875.30
	Region 5	$214.58	$429.16	$364.78	$364.78	$364.78	$611.55	$611.55	$611.55
	Region 6	$226.61	$453.22	$385.23	$385.23	$385.23	$645.83	$645.83	$645.83
	Region 7	$220.50	$441.00	$374.85	$374.85	$374.85	$628.42	$628.42	$628.42
	Region 8	$307.12	$614.24	$522.11	$522.11	$522.11	$875.30	$875.30	$875.30
EssentialCare Platinum Dental	Region 1	$397.25	$794.51	$675.33	$675.33	$675.33	$1,132.17	$1,132.17	$1,132.17
Age 29 Option	Region 2	$371.87	$743.74	$632.18	$632.18	$632.18	$1,059.83	$1,059.83	$1,059.83
	Region 3	$446.23	$892.47	$758.60	$758.60	$758.60	$1,271.77	$1,271.77	$1,271.77
	Region 4	$523.23	$1,046.47	$889.50	$889.50	$889.50	$1,491.21	$1,491.21	$1,491.21
	Region 5	$365.57	$731.14	$621.47	$621.47	$621.47	$1,041.88	$1,041.88	$1,041.88
	Region 6	$386.06	$772.13	$656.31	$656.31	$656.31	$1,100.28	$1,100.28	$1,100.28
	Region 7	$375.65	$751.31	$638.61	$638.61	$638.61	$1,070.61	$1,070.61	$1,070.61
	Region 8	$523.23	$1,046.47	$889.50	$889.50	$889.50	$1,491.21	$1,491.21	$1,491.21
EssentialCare Gold Dental	Region 1	$338.56	$677.12	$575.56	$575.56	$575.56	$964.90	$964.90	$964.90
Age 29 Option	Region 2	$316.93	$633.86	$538.78	$538.78	$538.78	$903.25	$903.25	$903.25
	Region 3	$380.31	$760.61	$646.52	$646.52	$646.52	$1,083.87	$1,083.87	$1,083.87
	Region 4	$445.93	$891.86	$758.08	$758.08	$758.08	$1,270.90	$1,270.90	$1,270.90
	Region 5	$311.56	$623.12	$529.65	$529.65	$529.65	$887.95	$887.95	$887.95
	Region 6	$329.03	$658.05	$559.34	$559.34	$559.34	$937.73	$937.73	$937.73
	Region 7	$320.15	$640.31	$544.26	$544.26	$544.26	$912.44	$912.44	$912.44
	Region 8	$445.93	$891.86	$758.08	$758.08	$758.08	$1,270.90	$1,270.90	$1,270.90
EssentialCare Silver Dental	Region 1	$299.57	$599.15	$509.27	$509.27	$509.27	$853.78	$853.78	$853.78
Age 29 Option	Region 2	$280.43	$560.87	$476.74	$476.74	$476.74	$799.23	$799.23	$799.23
	Region 3	$336.51	$673.02	$572.07	$572.07	$572.07	$959.06	$959.06	$959.06
	Region 4	$394.58	$789.15	$670.78	$670.78	$670.78	$1,124.54	$1,124.54	$1,124.54
	Region 5	$275.68	$551.36	$468.66	$468.66	$468.66	$785.69	$785.69	$785.69
	Region 6	$291.14	$582.27	$494.93	$494.93	$494.93	$829.74	$829.74	$829.74
	Region 7	$283.29	$566.57	$481.59	$481.59	$481.59	$807.36	$807.36	$807.36
	Region 8	$394.58	$789.15	$670.78	$670.78	$670.78	$1,124.54	$1,124.54	$1,124.54
EssentialCare Bronze Dental	Region 1	$236.70	$473.41	$402.40	$402.40	$402.40	$674.61	$674.61	$674.61
Age 29 Option	Region 2	$221.58	$443.16	$376.69	$376.69	$376.69	$631.51	$631.51	$631.51
	Region 3	$265.89	$531.78	$452.01	$452.01	$452.01	$757.79	$757.79	$757.79
	Region 4	$311.77	$623.54	$530.01	$530.01	$530.01	$888.55	$888.55	$888.55
	Region 5	$217.83	$435.65	$370.31	$370.31	$370.31	$620.81	$620.81	$620.81
	Region 6	$230.04	$460.08	$391.06	$391.06	$391.06	$655.61	$655.61	$655.61
	Region 7	$223.84	$447.67	$380.52	$380.52	$380.52	$637.93	$637.93	$637.93
	Region 8	$311.77	$623.54	$530.01	$530.01	$530.01	$888.55	$888.55	$888.55
Primary Select Platinum	Region 1	$375.43	$750.87	$638.24	$638.24	$638.24	$1,069.99	$1,069.99	$1,069.99
Age 29 Option	Region 2	$351.45	$702.89	$597.46	$597.46	$597.46	$1,001.62	$1,001.62	$1,001.62
	Region 3	$421.72	$843.45	$716.93	$716.93	$716.93	$1,201.92	$1,201.92	$1,201.92
	Region 4	$494.49	$988.99	$840.64	$840.64	$840.64	$1,409.31	$1,409.31	$1,409.31
	Region 5	$345.49	$690.98	$587.34	$587.34	$587.34	$984.65	$984.65	$984.65
	Region 6	$364.86	$729.72	$620.26	$620.26	$620.26	$1,039.85	$1,039.85	$1,039.85
	Region 7	$355.02	$710.04	$603.54	$603.54	$603.54	$1,011.81	$1,011.81	$1,011.81
	Region 8	$494.49	$988.99	$840.64	$840.64	$840.64	$1,409.31	$1,409.31	$1,409.31
Primary Select Gold	Region 1	$332.80	$665.60	$565.76	$565.76	$565.76	$948.48	$948.48	$948.48
Age 29 Option	Region 2	$311.54	$623.07	$529.61	$529.61	$529.61	$887.88	$887.88	$887.88
	Region 3	$373.83	$747.67	$635.52	$635.52	$635.52	$1,065.43	$1,065.43	$1,065.43
	Region 4	$438.34	$876.68	$745.18	$745.18	$745.18	$1,249.27	$1,249.27	$1,249.27
	Region 5	$306.26	$612.52	$520.64	$520.64	$520.64	$872.84	$872.84	$872.84
	Region 6	$323.43	$646.85	$549.83	$549.83	$549.83	$921.77	$921.77	$921.77
	Region 7	$314.71	$629.41	$535.00	$535.00	$535.00	$896.91	$896.91	$896.91
	Region 8	$438.34	$876.68	$745.18	$745.18	$745.18	$1,249.27	$1,249.27	$1,249.27
Primary Select Silver	Region 1	$293.93	$587.86	$499.68	$499.68	$499.68	$837.70	$837.70	$837.70
Age 29 Option	Region 2	$275.15	$550.30	$467.76	$467.76	$467.76	$784.18	$784.18	$784.18
	Region 3	$330.17	$660.34	$561.29	$561.29	$561.29	$940.99	$940.99	$940.99
	Region 4	$387.14	$774.29	$658.14	$658.14	$658.14	$1,103.36	$1,103.36	$1,103.36
	Region 5	$270.49	$540.98	$459.83	$459.83	$459.83	$770.89	$770.89	$770.89
	Region 6	$285.65	$571.30	$485.61	$485.61	$485.61	$814.11	$814.11	$814.11
	Region 7	$277.95	$555.90	$472.51	$472.51	$472.51	$792.15	$792.15	$792.15
	Region 8	$387.14	$774.29	$658.14	$658.14	$658.14	$1,103.36	$1,103.36	$1,103.36
Primary Select Silver EPO	Region 1	$277.33	$554.67	$471.47	$471.47	$471.47	$790.40	$790.40	$790.40
Age 29 Option	Region 2	$259.61	$519.23	$441.34	$441.34	$441.34	$739.90	$739.90	$739.90
	Region 3	$311.53	$623.06	$529.60	$529.60	$529.60	$887.86	$887.86	$887.86
	Region 4	$365.28	$730.57	$620.98	$620.98	$620.98	$1,041.06	$1,041.06	$1,041.06
	Region 5	$255.21	$510.43	$433.87	$433.87	$433.87	$727.36	$727.36	$727.36
	Region 6	$269.52	$539.04	$458.19	$458.19	$458.19	$768.14	$768.14	$768.14
	Region 7	$262.25	$524.51	$445.83	$445.83	$445.83	$747.42	$747.42	$747.42
	Region 8	$365.28	$730.57	$620.98	$620.98	$620.98	$1,041.06	$1,041.06	$1,041.06
Primary Select Bronze	Region 1	$202.13	$404.26	$343.62	$343.62	$343.62	$576.07	$576.07	$576.07
Age 29 Option	Region 2	$189.21	$378.43	$321.66	$321.66	$321.66	$539.26	$539.26	$539.26
	Region 3	$227.05	$454.10	$385.99	$385.99	$385.99	$647.09	$647.09	$647.09
	Region 4	$266.23	$532.46	$452.59	$452.59	$452.59	$758.75	$758.75	$758.75
	Region 5	$186.01	$372.02	$316.21	$316.21	$316.21	$530.12	$530.12	$530.12
	Region 6	$196.44	$392.87	$333.94	$333.94	$333.94	$559.84	$559.84	$559.84
	Region 7	$191.14	$382.28	$324.94	$324.94	$324.94	$544.74	$544.74	$544.74
	Region 8	$266.23	$532.46	$452.59	$452.59	$452.59	$758.75	$758.75	$758.75
PrimarySelect Platinum Dental	Region 1	$381.07	$762.14	$647.82	$647.82	$647.82	$1,086.05	$1,086.05	$1,086.05
Age 29 Option	Region 2	$356.72	$713.44	$606.43	$606.43	$606.43	$1,016.66	$1,016.66	$1,016.66
	Region 3	$428.05	$856.11	$727.69	$727.69	$727.69	$1,219.96	$1,219.96	$1,219.96
	Region 4	$501.92	$1,003.83	$853.26	$853.26	$853.26	$1,430.46	$1,430.46	$1,430.46
	Region 5	$350.68	$701.36	$596.15	$596.15	$596.15	$999.43	$999.43	$999.43
	Region 6	$370.34	$740.67	$629.57	$629.57	$629.57	$1,055.46	$1,055.46	$1,055.46
	Region 7	$360.35	$720.70	$612.60	$612.60	$612.60	$1,027.00	$1,027.00	$1,027.00
	Region 8	$501.92	$1,003.83	$853.26	$853.26	$853.26	$1,430.46	$1,430.46	$1,430.46
PrimarySelect Gold Dental	Region 1	$338.30	$676.60	$575.11	$575.11	$575.11	$964.15	$964.15	$964.15
Age 29 Option	Region 2	$316.68	$633.37	$538.36	$538.36	$538.36	$902.55	$902.55	$902.55
	Region 3	$380.01	$760.02	$646.02	$646.02	$646.02	$1,083.03	$1,083.03	$1,083.03
	Region 4	$445.58	$891.16	$757.49	$757.49	$757.49	$1,269.91	$1,269.91	$1,269.91
	Region 5	$311.32	$622.64	$529.24	$529.24	$529.24	$887.26	$887.26	$887.26
	Region 6	$328.77	$657.54	$558.91	$558.91	$558.91	$936.99	$936.99	$936.99
	Region 7	$319.90	$639.81	$543.84	$543.84	$543.84	$911.73	$911.73	$911.73
	Region 8	$445.58	$891.16	$757.49	$757.49	$757.49	$1,269.91	$1,269.91	$1,269.91
PrimarySelect Silver Dental	Region 1	$299.36	$598.72	$508.91	$508.91	$508.91	$853.18	$853.18	$853.18
Age 29 Option	Region 2	$280.23	$560.47	$476.40	$476.40	$476.40	$798.67	$798.67	$798.67
	Region 3	$336.27	$672.55	$571.66	$571.66	$571.66	$958.38	$958.38	$958.38
	Region 4	$394.30	$788.60	$670.31	$670.31	$670.31	$1,123.75	$1,123.75	$1,123.75
	Region 5	$275.49	$550.97	$468.33	$468.33	$468.33	$785.14	$785.14	$785.14
	Region 6	$290.93	$581.86	$494.58	$494.58	$494.58	$829.15	$829.15	$829.15
	Region 7	$283.09	$566.17	$481.24	$481.24	$481.24	$806.79	$806.79	$806.79
	Region 8	$394.30	$788.60	$670.31	$670.31	$670.31	$1,123.75	$1,123.75	$1,123.75
PrimarySelect Silver EPO Dental	Region 1	$282.76	$565.53	$480.70	$480.70	$480.70	$805.88	$805.88	$805.88
Age 29 Option	Region 2	$264.70	$529.40	$449.99	$449.99	$449.99	$754.39	$754.39	$754.39
	Region 3	$317.63	$635.26	$539.97	$539.97	$539.97	$905.24	$905.24	$905.24
	Region 4	$372.44	$744.87	$633.14	$633.14	$633.14	$1,061.45	$1,061.45	$1,061.45
	Region 5	$260.21	$520.43	$442.36	$442.36	$442.36	$741.61	$741.61	$741.61
	Region 6	$274.80	$549.60	$467.16	$467.16	$467.16	$783.18	$783.18	$783.18
	Region 7	$267.39	$534.78	$454.56	$454.56	$454.56	$762.06	$762.06	$762.06
	Region 8	$372.44	$744.87	$633.14	$633.14	$633.14	$1,061.45	$1,061.45	$1,061.45
PrimarySelect Bronze Dental	Region 1	$205.66	$411.32	$349.62	$349.62	$349.62	$586.12	$586.12	$586.12
Age 29 Option	Region 2	$192.52	$385.04	$327.28	$327.28	$327.28	$548.68	$548.68	$548.68

Freelancers Health Service Corporation
2014 Individual Rate Filing
Rates

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	Individual	Couple	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Couple and One Dependent	Couple and Two Dependents	Couple and Three or More Dependents
Region 3	$231.02	$462.03	$392.73	$392.73	$392.73	$658.39	$658.39	$658.39
Region 4	$270.88	$541.76	$460.49	$460.49	$460.49	$772.00	$772.00	$772.00
Region 5	$189.26	$378.51	$321.74	$321.74	$321.74	$539.38	$539.38	$539.38
Region 6	$199.87	$399.73	$339.77	$339.77	$339.77	$569.62	$569.62	$569.62
Region 7	$194.48	$388.95	$330.61	$330.61	$330.61	$554.26	$554.26	$554.26
Region 8	$270.88	$541.76	$460.49	$460.49	$460.49	$772.00	$772.00	$772.00

Freelancers Health Services Corporation
2014 Individual Rate Filing
Benefit Grid - STANDARD PLANS

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Plans:	Essential Care Platinum EssentialCare Platinum Dental Essential Care Platinum Child-Only EssentialCare Platinum Child-Only Dental Essential Care Platinum Age 29 Option EssentialCare Platinum Dental Age 29 Option		Essential Care Gold EssentialCare Gold Dental Essential Care Gold Child-Only EssentialCare Gold Child-Only Dental Essential Care Gold Age 29 Option EssentialCare Gold Dental Age 20 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0	Not Applicable	$600	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$2,000	Not Applicable	$4,000	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	Not Covered	$0	Not Covered
Physician and Other Services				
Office Visit	$15 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	$100 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$100 after deductible is met	$100 after deductible is met	$150 after deductible is met	$150 after deductible is met
Ambulance	$100 after deductible is met	$100 after deductible is met	$150 after deductible is met	$150 after deductible is met
Urgent Care Center	$55 after deductible is met	Not Covered	$60 after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	$500 after deductible is met	Not Covered	$1,000 after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	$100 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Skilled Nursing Facility	$500 after deductible is met	Not Covered	$1,000 after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$35 after deductible is met	Not Covered	$40 after deductible is met	Not Covered
EKG	$35 after deductible is met	Not Covered	$40 after deductible is met	Not Covered
Routine Radiology	$35 after deductible is met	Not Covered	$40 after deductible is met	Not Covered
Advanced Radiology	$35 after deductible is met	Not Covered	$40 after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	$500 after deductible is met	Not Covered	$1,000 after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	$500 after deductible is met	Not Covered	$1,000 after deductible is met	Not Covered
Outpatient Mental Health	$15 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	$500 after deductible is met	Not Covered	$1,000 after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	$500 after deductible is met	Not Covered	$1,000 after deductible is met	Not Covered
Outpatient Substance Abuse	$15 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$15 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$15 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	$35 after deductible is met	Not Covered	$40 after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	$25 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Cardiac Rehabilitation	$25 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Pulmonary Rehabilitation	$25 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Chemotherapy	$15 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Home Health Care	$15 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Prescription Drug Coverage				
Prescription Plan	$10/$30/$60	Not Covered	$10/$35/$70	Not Covered
Maintenance Medications	$10/$30/$60	Not Covered	$10/$35/$70	Not Covered
Vision Services				
Medical Exam	$15 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Standard Plastic Lenses	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Frames	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered

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Freelancers Health Services Corporation
2014 Individual Rate Filing
Benefit Grid - STANDARD PLANS

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Plans:	Essential Care Silver EssentialCare Silver Dental Essential Care Silver Child-Only EssentialCare Silver Child-Only Dental Essential Care Silver Age 29 Option EssentialCare Silver Dental Age 20 Option		Essential Care Silver CSR 200-250% FPL EssentialCare Silver CSR 200-250% FPL Dental Essential Care Silver CSR 200-250% FPL Child-Only EssentialCare Silver CSR 200-250% FPL Child-Only Dental Essential Care Silver CSR 200-250% FPL Age 29 Option EssentialCare Silver CSR 200-250% FPL Dental Age 20 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$2,000	Not Applicable	$1,750	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$5,500	Not Applicable	$4,000	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	Not Covered	$0	Not Covered
Physician and Other Services				
Office Visit	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	$100 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$150 after deductible is met	$150 after deductible is met	$150 after deductible is met	$150 after deductible is met
Ambulance	$150 after deductible is met	$150 after deductible is met	$150 after deductible is met	$150 after deductible is met
Urgent Care Center	$70 after deductible is met	Not Covered	$70 after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	$1,500 after deductible is met	Not Covered	$1,500 after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	$100 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Skilled Nursing Facility	$1,500 after deductible is met	Not Covered	$1,500 after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$50 after deductible is met	Not Covered	$50 after deductible is met	Not Covered
EKG	$50 after deductible is met	Not Covered	$50 after deductible is met	Not Covered
Routine Radiology	$50 after deductible is met	Not Covered	$50 after deductible is met	Not Covered
Advanced Radiology	$50 after deductible is met	Not Covered	$50 after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	$1,500 after deductible is met	Not Covered	$1,500 after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	$1,500 after deductible is met	Not Covered	$1,500 after deductible is met	Not Covered
Outpatient Mental Health	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	$1,500 after deductible is met	Not Covered	$1,500 after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	$1,500 after deductible is met	Not Covered	$1,500 after deductible is met	Not Covered
Outpatient Substance Abuse	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	$50 after deductible is met	Not Covered	$50 after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Cardiac Rehabilitation	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Pulmonary Rehabilitation	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered
Chemotherapy	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Home Health Care	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Prescription Drug Coverage				
Prescription Plan	$10/$35/$70	Not Covered	$10/$35/$70	Not Covered
Maintenance Medications	$10/$35/$70	Not Covered	$10/$35/$70	Not Covered
Vision Services				
Medical Exam	$30 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Standard Plastic Lenses	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered
Frames	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered

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Freelancers Health Services Corporation
2014 Individual Rate Filing
Benefit Grid - STANDARD PLANS

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Plans:	Essential Care Silver CSR 150-200% FPL EssentialCare Silver CSR 150-200% FPL Dental Essential Care Silver CSR 150-200% FPL Child-Only EssentialCare Silver CSR 150-200% FPL Child-Only Dental Essential Care Silver CSR 150-200% FPL Age 29 Option EssentialCare Silver CSR 150-200% FPL Dental Age 20 Option		Essential Care Silver CSR 100-150% FPL EssentialCare Silver CSR 100-150% FPL Dental Essential Care Silver CSR 100-150% FPL Child-Only EssentialCare Silver CSR 100-150% FPL Child-Only Dental Essential Care Silver CSR 100-150% FPL Age 29 Option EssentialCare Silver CSR 100-150% FPL Dental Age 20 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$250	Not Applicable	$0	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$2,000	Not Applicable	$1,000	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	Not Covered	$0	Not Covered
Physician and Other Services				
Office Visit	$15 after deductible is met	Not Covered	$10 after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	$75 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$75 after deductible is met	$75 after deductible is met	$50 after deductible is met	$50 after deductible is met
Ambulance	$75 after deductible is met	$75 after deductible is met	$50 after deductible is met	$50 after deductible is met
Urgent Care Center	$50 after deductible is met	Not Covered	$30 after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	$250 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	$75 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Skilled Nursing Facility	$250 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$35 after deductible is met	Not Covered	$20 after deductible is met	Not Covered
EKG	$35 after deductible is met	Not Covered	$20 after deductible is met	Not Covered
Routine Radiology	$35 after deductible is met	Not Covered	$20 after deductible is met	Not Covered
Advanced Radiology	$35 after deductible is met	Not Covered	$20 after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	$250 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	$250 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Outpatient Mental Health	$15 after deductible is met	Not Covered	$10 after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	$250 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	$250 after deductible is met	Not Covered	$100 after deductible is met	Not Covered
Outpatient Substance Abuse	$15 after deductible is met	Not Covered	$10 after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$15 after deductible is met	Not Covered	$10 after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$15 after deductible is met	Not Covered	$10 after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	$35 after deductible is met	Not Covered	$20 after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	$25 after deductible is met	Not Covered	$15 after deductible is met	Not Covered
Cardiac Rehabilitation	$25 after deductible is met	Not Covered	$15 after deductible is met	Not Covered
Pulmonary Rehabilitation	$25 after deductible is met	Not Covered	$15 after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Chemotherapy	$15 after deductible is met	Not Covered	$10 after deductible is met	Not Covered
Home Health Care	$15 after deductible is met	Not Covered	$10 after deductible is met	Not Covered
Prescription Drug Coverage				
Prescription Plan	$9/$20/$40	Not Covered	$6/$15/$30	Not Covered
Maintenance Medications	$9/$20/$40	Not Covered	$6/$15/$30	Not Covered
Vision Services				
Medical Exam	$15 after deductible is met	Not Covered	$10 after deductible is met	Not Covered
Standard Plastic Lenses	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Frames	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered

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	Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - STANDARD PLANS			
	Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003			
Plans:	**Essential Care Bronze EssentialCare Bronze Dental Essential Care Bronze Child-Only EssentialCare Bronze Child-Only Dental Essential Care Bronze Age 29 Option EssentialCare Bronze Dental Age 29 Option**		**Essential Care Catastrophic EssentialCare Catastrophic Dental Essential Care Bronze Age 29 Option EssentialCare Bronze Dental Age 29 Option**	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$3,000	Not Applicable	$6,350	Not Applicable
Coinsurance	50%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$6,350	Not Applicable	$6,350	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	Not Covered	$0	Not Covered
Physician and Other Services				
Office Visit	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	50% cost sharing after deductible is met	50% cost sharing after deductible is met	0% cost sharing after deductible is met	0% cost sharing after deductible is met
Ambulance	50% cost sharing after deductible is met	50% cost sharing after deductible is met	0% cost sharing after deductible is met	0% cost sharing after deductible is met
Urgent Care Center	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Skilled Nursing Facility	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
EKG	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Routine Radiology	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Advanced Radiology	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Outpatient Mental Health	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Outpatient Substance Abuse	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Cardiac Rehabilitation	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Pulmonary Rehabilitation	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Chemotherapy	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Home Health Care	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Prescription Drug Coverage				
Prescription Plan	$10/$35/$70	Not Covered	0% cost sharing after deductible is met	Not Covered
Maintenance Medications	$10/$35/$70	Not Covered	0% cost sharing after deductible is met	Not Covered
Vision Services				
Medical Exam	$10 after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Standard Plastic Lenses	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Frames	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered
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	Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - STANDARD PLANS	
	Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003	
Plans:	**Essential Care American Indian/Alaska Native = or < 300% FPL** **EssentialCare American Indian/Alaska Native = or < 300% FPLDental** **Essential Care American Indian/Alaska Native = or < 300% FPLChild-Only** **EssentialCare American Indian/Alaska Native = or < 300% FPLChild-Only Dental** **Essential Care American Indian/Alaska Native = or < 300% FPLAge 29 Option** **EssentialCare American Indian/Alaska Native = or < 300% FPLDental Age 20 Option**	
Benefit Summary	**In-Network**	**Out-of-Network**
Deductible	$0	Not Applicable
Coinsurance	100%	Not Applicable
Out of Pocket Maximum	$0	Not Applicable
Preventive Services		
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	Not Covered
Physician and Other Services		
Office Visit	0% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	0% cost sharing after deductible is met	Not Covered
Emergency & Urgent Care Services		
Emergency Room	0% cost sharing after deductible is met	0% cost sharing after deductible is met
Ambulance	0% cost sharing after deductible is met	0% cost sharing after deductible is met
Urgent Care Center	0% cost sharing after deductible is met	Not Covered
Hospital Services		
Inpatient Hospital	0% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	0% cost sharing after deductible is met	Not Covered
Skilled Nursing Facility	0% cost sharing after deductible is met	Not Covered
Diagnostic Testing Services		
Laboratory Testing	0% cost sharing after deductible is met	Not Covered
EKG	0% cost sharing after deductible is met	Not Covered
Routine Radiology	0% cost sharing after deductible is met	Not Covered
Advanced Radiology	0% cost sharing after deductible is met	Not Covered
Maternity Services		
Inpatient Maternity	0% cost sharing after deductible is met	Not Covered
Mental Health & Substance Abuse Services		
Inpatient Mental Health	0% cost sharing after deductible is met	Not Covered
Outpatient Mental Health	0% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	0% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	0% cost sharing after deductible is met	Not Covered
Outpatient Substance Abuse	0% cost sharing after deductible is met	Not Covered
Diabetic Supplies and Services		
Insulin and Other Oral Agents	0% cost sharing after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	0% cost sharing after deductible is met	Not Covered
Rehabilitation Services		
Chiropractic Services	0% cost sharing after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	0% cost sharing after deductible is met	Not Covered
Cardiac Rehabilitation	0% cost sharing after deductible is met	Not Covered
Pulmonary Rehabilitation	0% cost sharing after deductible is met	Not Covered
Additional Services		
Durable Medical Equipment	0% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	0% cost sharing after deductible is met	Not Covered
Chemotherapy	0% cost sharing after deductible is met	Not Covered
Home Health Care	0% cost sharing after deductible is met	Not Covered
Prescription Drug Coverage		
Prescription Plan	0% cost sharing after deductible is met	Not Covered
Maintenance Medications	0% cost sharing after deductible is met	Not Covered
Vision Services		
Medical Exam	0% cost sharing after deductible is met	Not Covered
Standard Plastic Lenses	0% cost sharing after deductible is met	Not Covered
Frames	0% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	0% cost sharing after deductible is met	Not Covered
Dental Services		
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered
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Freelancers Health Services Corporation
2014 Individual Rate Filing
Benefit Grid - NON-STANDARD PLANS

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Plans:	**Primary Select Platinum** **PrimarySelect Platinum Dental** **Primary Select Platinum Age 29 Option** **PrimarySelect Platinum Dental Age 29 Option**		**Primary Select Gold** **PrimarySelect Gold Dental** **Primary Select Gold Age 29 Option** **PrimarySelect Gold Dental Age 29 Option**	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0	Not Applicable	$250	Not Applicable
Coinsurance	20%	Not Applicable	20%	Not Applicable
Out of Pocket Maximum	$1,400	Not Applicable	$3,500	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	Not Covered	$0	Not Covered
Physician and Other Services				
Office Visit	$0 Copay	Not Covered	$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible
Ambulance	$100 Copay	$100 Copay	$150 Copay	$150 Copay
Urgent Care Center	$100 Copay	Not Covered	$100 Copay	Not Covered
Hospital Services				
Inpatient Hospital	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Surgical Procedures (Facility)	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Skilled Nursing Facility	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$75 Copay	Not Covered	$75 Copay	Not Covered
EKG	$75 Copay	Not Covered	$75 Copay	Not Covered
Routine Radiology	$75 Copay	Not Covered	$75 Copay	Not Covered
Advanced Radiology	$75 Copay	Not Covered	$75 Copay	Not Covered
Maternity Services				
Inpatient Maternity	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Mental Health	$0 Copay	Not Covered	$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Inpatient Substance Abuse - Detox	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Substance Abuse	$0 Copay	Not Covered	$0 Copay	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$0 Copay	Not Covered	$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 Copay	Not Covered	$0 Copay	Not Covered
Rehabilitation Services				
Chiropractic Services	$75 Copay	Not Covered	$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	$30 Copay	Not Covered	$30 Copay	Not Covered
Cardiac Rehabilitation	$30 Copay	Not Covered	$30 Copay	Not Covered
Pulmonary Rehabilitation	$30 Copay	Not Covered	$30 Copay	Not Covered
Additional Services				
Durable Medical Equipment	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Prosthetics and Appliances	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Chemotherapy	$15 Copay	Not Covered	$25 Copay	Not Covered
Home Health Care	$15 Copay	Not Covered	$25 Copay	Not Covered
Prescription Drug Coverage				
Prescription Plan	$0/$35 after Deductible /$70 after Deductible	Not Covered	$0/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$0/$35 after Deductible /$70 after Deductible	Not Covered	$0/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services				
Medical Exam	$15 Copay	Not Covered	$25 Copay after deductible is met	Not Covered
Standard Plastic Lenses	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Frames	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Conventional Contact Lenses	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered

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Plans:	Primary Select Silver PrimarySelect Silver Dental Primary Select Silver Age 29 Option PrimarySelect Silver Dental Age 29 Option		Primary Select Silver CSR 200-250% FPL PrimarySelect Silver CSR 200-250% FPL Dental Primary Select Silver CSR 200-250% FPL Age 29 Option PrimarySelect Silver CSR 200-250% FPL Dental Age 29 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$2,000	Not Applicable	$2,000	Not Applicable
Coinsurance	20%	Not Applicable	20%	Not Applicable
Out of Pocket Maximum	$6,350	Not Applicable	$5,200	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	Not Covered	$0	Not Covered
Physician and Other Services				
Office Visit	$0 Copay	Not Covered	$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible
Ambulance	$150 Copay	$150 Copay	$150 Copay	$150 Copay
Urgent Care Center	$100 Copay	Not Covered	$100 Copay	Not Covered
Hospital Services				
Inpatient Hospital	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Surgical Procedures (Facility)	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Skilled Nursing Facility	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$75 Copay	Not Covered	$75 Copay	Not Covered
EKG	$75 Copay	Not Covered	$75 Copay	Not Covered
Routine Radiology	$75 Copay	Not Covered	$75 Copay	Not Covered
Advanced Radiology	$75 Copay	Not Covered	$75 Copay	Not Covered
Maternity Services				
Inpatient Maternity	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Mental Health	$0 Copay	Not Covered	$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Inpatient Substance Abuse - Detox	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Substance Abuse	$0 Copay	Not Covered	$0 Copay	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$0 Copay	Not Covered	$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 Copay	Not Covered	$0 Copay	Not Covered
Rehabilitation Services				
Chiropractic Services	$75 Copay	Not Covered	$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	$30 Copay	Not Covered	$30 Copay	Not Covered
Cardiac Rehabilitation	$30 Copay	Not Covered	$30 Copay	Not Covered
Pulmonary Rehabilitation	$30 Copay	Not Covered	$30 Copay	Not Covered
Additional Services				
Durable Medical Equipment	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Prosthetics and Appliances	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Chemotherapy	$30 Copay	Not Covered	$30 Copay	Not Covered
Home Health Care	$30 Copay	Not Covered	$30 Copay	Not Covered
Prescription Drug Coverage				
Prescription Plan	$0/$35 after Deductible /$70 after Deductible	Not Covered	$0/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$0/$35 after Deductible /$70 after Deductible	Not Covered	$0/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services				
Medical Exam	$30 Copay after deductible is met	Not Covered	$30 Copay after deductible is met	Not Covered
Standard Plastic Lenses	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Frames	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Conventional Contact Lenses	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered

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Plans:	Primary Select Silver CSR 150-200% FPL PrimarySelect Silver CSR 150-200% FPL Dental Primary Select Silver CSR 150-200% FPL Age 29 Option PrimarySelect Silver CSR 150-200% FPL Dental Age 29 Option		Primary Select Silver CSR 100-150% FPL PrimarySelect Silver CSR 100-150% FPL Dental Primary Select Silver CSR 100-150% FPL Age 29 Option PrimarySelect Silver CSR 100-150% FPL Dental Age 29 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0	Not Applicable	$0	Not Applicable
Coinsurance	20%	Not Applicable	20%	Not Applicable
Out of Pocket Maximum	$2,000	Not Applicable	$500	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	Not Covered	$0	Not Covered
Physician and Other Services				
Office Visit	$0 Copay	Not Covered	$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible
Ambulance	$75 Copay	$75 Copay	$50 Copay	$50 Copay
Urgent Care Center	$100 Copay	Not Covered	$100 Copay	Not Covered
Hospital Services				
Inpatient Hospital	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Surgical Procedures (Facility)	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Skilled Nursing Facility	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$75 Copay	Not Covered	$75 Copay	Not Covered
EKG	$75 Copay	Not Covered	$75 Copay	Not Covered
Routine Radiology	$75 Copay	Not Covered	$75 Copay	Not Covered
Advanced Radiology	$75 Copay	Not Covered	$75 Copay	Not Covered
Maternity Services				
Inpatient Maternity	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Mental Health	$0 Copay	Not Covered	$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Inpatient Substance Abuse - Detox	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Substance Abuse	$0 Copay	Not Covered	$0 Copay	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$0 Copay	Not Covered	$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 Copay	Not Covered	$0 Copay	Not Covered
Rehabilitation Services				
Chiropractic Services	$75 Copay	Not Covered	$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	$30 Copay	Not Covered	$30 Copay	Not Covered
Cardiac Rehabilitation	$30 Copay	Not Covered	$30 Copay	Not Covered
Pulmonary Rehabilitation	$30 Copay	Not Covered	$30 Copay	Not Covered
Additional Services				
Durable Medical Equipment	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Prosthetics and Appliances	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Chemotherapy	$15 Copay	Not Covered	$10 Copay	Not Covered
Home Health Care	$15 Copay	Not Covered	$10 Copay	Not Covered
Prescription Drug Coverage				
Prescription Plan	$0/$35 after Deductible /$70 after Deductible	Not Covered	$0/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$0/$35 after Deductible /$70 after Deductible	Not Covered	$0/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services				
Medical Exam	$15 Copay	Not Covered	$10 Copay	Not Covered
Standard Plastic Lenses	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Frames	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Conventional Contact Lenses	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered

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Plans:	Primary Select Bronze PrimarySelect Bronze Dental Primary Select Bronze Age 29 Option PrimarySelect Bronze Dental Age 29 Option		Primary Select EPO Silver PrimarySelect EPO Silver Dental Primary Select EPO Silver Age 29 Option PrimarySelect EPO Silver Dental Age 29 Option		
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network (Preferred)**	**In-Network (Participating)**	**Out-of-Network**
Deductible	$6,350	Not Applicable	$2,000	$2,000	Not Applicable
Coinsurance	100%	Not Applicable	20%	20%	Not Applicable
Out of Pocket Maximum	$6,350	Not Applicable	$6,350	$6,350	Not Applicable
Preventive Services					
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	Not Covered	$0	$0	Not Covered
Physician and Other Services					
Office Visit	$0 Copay	Not Covered	$0 Copay if using selected Doctor	$30 Copay after Deductible	Not Covered
Outpatient Surgical Procedures (in physician's office)	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services					
Emergency Room	Subject To Deductible	Subject To Deductible	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible
Ambulance	Subject To Deductible	Subject To Deductible	$150 Copay after Deductible	$150 Copay after Deductible	$150 Copay after Deductible
Urgent Care Center	Subject To Deductible	Not Covered	$100 Copay after Deductible	$100 Copay after Deductible	Not Covered
Hospital Services					
Inpatient Hospital	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services					
Laboratory Testing	Subject To Deductible	Not Covered	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
EKG	Subject To Deductible	Not Covered	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
Routine Radiology	Subject To Deductible	Not Covered	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
Advanced Radiology	Subject To Deductible	Not Covered	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
Maternity Services					
Inpatient Maternity	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services					
Inpatient Mental Health	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	$0 Copay	Not Covered	$0 Copay	$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	$0 Copay	Not Covered	$0 Copay	$0 Copay	Not Covered
Diabetic Supplies and Services					
Insulin and Other Oral Agents	$0 Copay	Not Covered	$0 Copay	$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 Copay	Not Covered	$0 Copay	$0 Copay	Not Covered
Rehabilitation Services					
Chiropractic Services	Subject To Deductible	Not Covered	$75 Copay	$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	Subject To Deductible	Not Covered	$30 Copay	$30 Copay	Not Covered
Cardiac Rehabilitation	Subject To Deductible	Not Covered	$30 Copay	$30 Copay	Not Covered
Pulmonary Rehabilitation	Subject To Deductible	Not Covered	$30 Copay	$30 Copay	Not Covered
Additional Services					
Durable Medical Equipment	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Chemotherapy	Subject To Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Home Health Care	Subject To Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Prescription Drug Coverage					
Prescription Plan	$0/Subject To Deductible/Subject To Deductible	Not Covered	$0/$35 after Deductible /$70 after Deductible	$0/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$0/Subject To Deductible/Subject To Deductible	Not Covered	$0/$35 after Deductible /$70 after Deductible	$0/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services					
Medical Exam	Subject To Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Standard Plastic Lenses	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Frames	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Conventional Contact Lenses	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Dental Services					
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Pediatric Coverage with Dental Option	Not Covered

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Plans:	**Primary Select EPO Silver CSR 200-250% FPL** **PrimarySelect EPO Silver CSR 200-250% FPL Dental** **Primary Select EPO Silver CSR 200-250% FPL Age 29 Option** **PrimarySelect EPO Silver CSR 200-250% FPL Dental Age 29 Option**		
Benefit Summary	**In-Network (Preferred)**	**In-Network (Participating)**	**Out-of-Network**
Deductible	$2,000	$2,000	Not Applicable
Coinsurance	20%	20%	Not Applicable
Out of Pocket Maximum	$5,200	$5,200	Not Applicable
Preventive Services			
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	$0	Not Covered
Physician and Other Services			
Office Visit	$0 Copayment with Selected Doctor	$30 Copay after Deductible any other PCP	Not Covered
Outpatient Surgical Procedures (in physician's office)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services			
Emergency Room	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible
Ambulance	$150 Copay after Deductible	$150 Copay after Deductible	$150 Copay after Deductible
Urgent Care Center	$100 Copay after Deductible	$100 Copay after Deductible	Not Covered
Hospital Services			
Inpatient Hospital	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services			
Laboratory Testing	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
EKG	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
Routine Radiology	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
Advanced Radiology	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
Maternity Services			
Inpatient Maternity	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services			
Inpatient Mental Health	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	$0 Copay	$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	$0 Copay	$0 Copay	Not Covered
Diabetic Supplies and Services			
Insulin and Other Oral Agents	$0 Copay	$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 Copay	$0 Copay	Not Covered
Rehabilitation Services			
Chiropractic Services	$75 Copay	$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	$30 Copay	$30 Copay	Not Covered
Cardiac Rehabilitation	$30 Copay	$30 Copay	Not Covered
Pulmonary Rehabilitation	$30 Copay	$30 Copay	Not Covered
Additional Services			
Durable Medical Equipment	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Chemotherapy	$30 Copay	$30 Copay	Not Covered
Home Health Care	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Prescription Drug Coverage			
Prescription Plan	$0/$35 after Deductible /$70 after Deductible	$0/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$0/$35 after Deductible /$70 after Deductible	$0/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services			
Medical Exam	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Standard Plastic Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Frames	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Conventional Contact Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Dental Services			
Preventive and Routine	Pediatric Coverage with Dental Option	Pediatric Coverage with Dental Option	Not Covered

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2014 Individual Rate Filing
Benefit Grid - NON-STANDARD PLANS

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Plans:	**Primary Select EPO Silver CSR 150-200% FPL** **PrimarySelect EPO Silver CSR 150-200% FPL Dental** **Primary Select EPO Silver CSR 150-200% FPL Age 29 Option** **PrimarySelect EPO Silver CSR 150-200% FPL Dental Age 29 Option**		
Benefit Summary	**In-Network (Preferred)**	**In-Network (Participating)**	**Out-of-Network**
Deductible	$0	$0	Not Applicable
Coinsurance	20%	20%	Not Applicable
Out of Pocket Maximum	$2,000	$2,000	Not Applicable
Preventive Services			
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	$0	Not Covered
Physician and Other Services			
Office Visit	$0 Copayment with Selected Doctor	$30 Copay after Deductible any other PCP	Not Covered
Outpatient Surgical Procedures (in physician's office)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services			
Emergency Room	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible
Ambulance	$100 Copay after Deductible	$100 Copay after Deductible	$100 Copay after Deductible
Urgent Care Center	$100 Copay after Deductible	$100 Copay after Deductible	Not Covered
Hospital Services			
Inpatient Hospital	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services			
Laboratory Testing	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
EKG	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
Routine Radiology	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
Advanced Radiology	$75 Copay after Deductible	$75 Copay after Deductible	Not Covered
Maternity Services			
Inpatient Maternity	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services			
Inpatient Mental Health	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	$0 Copay	$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	$0 Copay	$0 Copay	Not Covered
Diabetic Supplies and Services			
Insulin and Other Oral Agents	$0 Copay	$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 Copay	$0 Copay	Not Covered
Rehabilitation Services			
Chiropractic Services	$75 Copay	$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	$30 Copay	$30 Copay	Not Covered
Cardiac Rehabilitation	$30 Copay	$30 Copay	Not Covered
Pulmonary Rehabilitation	$30 Copay	$30 Copay	Not Covered
Additional Services			
Durable Medical Equipment	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Chemotherapy	$15 Copay	$15 Copay	Not Covered
Home Health Care	$15 Copay	$15 Copay	Not Covered
Prescription Drug Coverage			
Prescription Plan	$0/$35 after Deductible /$70 after Deductible	$0/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$0/$35 after Deductible /$70 after Deductible	$0/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services			
Medical Exam	$15 Copay after Deductible	$15 Copay after Deductible	Not Covered
Standard Plastic Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Frames	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Conventional Contact Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Dental Services			
Preventive and Routine	Pediatric Coverage with Dental Option	Pediatric Coverage with Dental Option	Not Covered

This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.

All indicated benefits assume the member has appropriate authorization to receive services.

Certain benefits stated in this benefit summary are pending NYS approval.

	Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - NON-STANDARD PLANS		
	Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003		
Plans:	**Primary Select EPO Silver CSR 100-150% FPL PrimarySelect EPO Silver CSR 100-150% FPL Dental Primary Select EPO Silver CSR 100-150% FPL Age 29 Option PrimarySelect EPO Silver CSR 100-150% FPL Dental Age 29 Option**		
Benefit Summary	**In-Network (Preferred)**	**In-Network (Participating)**	**Out-of-Network**
Deductible	$0	$0	Not Applicable
Coinsurance	20%	20%	Not Applicable
Out of Pocket Maximum	$500	$500	Not Applicable
Preventive Services			
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	$0	$0	Not Covered
Physician and Other Services			
Office Visit	$0 Copayment with Selected Doctor	$30 Copay after Deductible any other PCP	Not Covered
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Hospital Services			
Inpatient Hospital	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
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Diabetic Supplies and Services			
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Physical - Occupational - Speech Therapies	$30 Copay	$30 Copay	Not Covered
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Pulmonary Rehabilitation	$30 Copay	$30 Copay	Not Covered
Additional Services			
Durable Medical Equipment	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Chemotherapy	$10 Copay	$10 Copay	Not Covered
Home Health Care	$10 Copay	$10 Copay	Not Covered
Prescription Drug Coverage			
Prescription Plan	$0/$35 after Deductible /$70 after Deductible	$0/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$0/$35 after Deductible /$70 after Deductible	$0/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services			
Medical Exam	$10 Copay after Deductible	$10 Copay after Deductible	Not Covered
Standard Plastic Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Frames	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
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Dental Services			
Preventive and Routine	Pediatric Coverage with Dental Option	Pediatric Coverage with Dental Option	Not Covered
	This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage. All indicated benefits assume the member has appropriate authorization to receive services. Certain benefits stated in this benefit summary are pending NYS approval.		

Freelancers Health Service Corporation
2014 Individual Rate Filing
Rating Region Composition

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

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

Freelancers Health Service Corporation 2014 Individual Rate Filing Commission Schedule	
Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003	
Individual Schedule:	1% of Premium

Freelancers Health Service Corporation
2014 Individual Rate Filing
Expected Loss Ratio

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Federal ACA Loss Ratio	88.4%

ACA MLR = (Incurred Claims + Quality Initiatives - Gross Reinsurance Recoveries) / (Earned Premium - Taxes and Fees)

New York State Loss Ratio	82.4%

NY MLR = (Incurred Claims + HCRA Surcharge + Covered Lives Assessment (GME) - Gross Reinsurance Recoveries) / Earned Premium

Supporting Document Schedules

Satisfied - Item:	A&H Product Checklist
Comments:	
Attachment(s):	Individual Off Exchange Checklist_5-14.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Freelancers Health Services Corp Flesch Score Cert_Executed.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variability
Comments:	
Attachment(s):	Memo indiv 003 rev_v3.0_OFFexchange.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Black-lined Copy of Model Language
Comments:	
Attachment(s):	Catastrophic OFF EXCHANGE_redline.pdf Individual EPO OFF EXCHANGE_redline.pdf Individual Standard OFF Exchange_redline.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum
Bypass Reason:	Actuarial Memorandum attached in item below "Actuarial Memorandum and Certifications"
Attachment(s):	
Item Status:	
Status Date:	

State: New York **Filing Company:** Freelancers Health Service Corporation
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: FHSC IND OFF Exchange
Project Name/Number: /

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	Actuarial Memorandum - FHSC - IM.pdf Attachment C IM (5-11-2013).xlsx Act Memo - Attachment E - Reliance Letter.pdf Act Memo - Attachment D -Quality Improvement Cost Containment.pdf Attachment B IM (5-21-2013) - Obj #1.pdf Attachment B IM (5-21-2013) - Obj #1.xlsx Attachment A IM (5-25-2013).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations
Comments:	
Attachment(s):	Attachment A.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 1-General Information
Comments:	
Attachment(s):	Required Exhibit 1 (4-22-13).xls
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 8-Adjustment Factors to Index Rate
Comments:	
Attachment(s):	Exhibit 8 (5-21-2013) - Obj #10.xlsx Exhibit 8 (5-21-2013) - Obj #10.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 9-Summary of Administrative Expenses

State: New York **Filing Company:** Freelancers Health Service Corporation
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: FHSC IND OFF Exchange
Project Name/Number: /

Comments:	
Attachment(s):	Exhibit 9 (5-24-2013).pdf Exhibit 9 (5-24-2013).xls
Item Status:	
Status Date:	

Bypassed - Item:	Redacted Documents for Web Posting-NG Off Exchange
Bypass Reason:	We are awaiting clarification from Mr. Powell to determine whether this requirement is applicable to to new companies.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	FHSC 2014 NY Individual URRT (5-25-2013).xlsm FHSC 2014 NY Individual URRT (5-25-2013)m.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rider to Extend Coverage for Young Adults
Comments:	Please be advised that the attached rider will be made available as appropriate. The attached rider was approved on July 30, 2013 under Department File No.: 2013640172 (SERFF Tracking No.: HNMN-129003992).
Attachment(s):	RIDER TO EXTEND COVERAGE FOR YOUNG ADULTS_v2_0.pdf
Item Status:	
Status Date:	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Major Medical and Other Similar-Type Comprehensive Health Insurance Checklist for Individuals

As of 5/3/13

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".

Major Medical and Other Similar-Type Comprehensive Health Insurance Checklist for Individuals

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

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) §3102(c)	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.	FHSC-IND003

		No agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions. *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.	Yes
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.	TBD
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF filing description or a letter of submission that contains the following: • The identifying form number of each form submitted. §52.33(a) • If the form is a policy or contract, the letter must indicate that the policy or contract is submitted pursuant to 11 NYCRR 52.7. §52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number,	Yes

		control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is other than a policy or contract form, the letter must identify the form number and approval date of the policy or contract with which it will be used. If the form is for general use, the Department may accept a description of the type of policy or contract with which it may be used in lieu of the form number and approval date. §52.33(g) • If the form is a policy or contract, the letter must identify the form numbers and dates of approval of any applications previously approved to be used with the policy or contract unless the application is required to be attached to the policy or contract upon submission. §52.33(h) • If the policy or contract is designed to be used with insert pages, the letter must contain a statement of the insert page forms which must always be included in the policy or contract and a list of all optional pages, together with an explanation of their use. § 52.33(i) • *Note: Submission letters and or the SERFF filing description should advise as to whether the policy or contract is intended for internet sales and should describe any proposed electronic procedures and/or the proposed use of electronic signatures associated with the sale of the policy or contract.*	
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.	
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.	Authorization statement not included
Fraud Warning Statement	§403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	FHSC - EF001
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).	The application does not contain any of the prohibited questions or provisions.

Verification of Compliance with Pediatric Essential Dental Health Benefit.	45 CFR § 156.150	In order to verify whether an individual has obtained stand-alone dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange, insurers should use the following language on their application/enrollment form: A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? Yes No B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____ If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name Model Language Used? Yes ☒ No ☐	Model Language	This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	IND003, Page 1
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover).	IND003, Page 1
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.	IND003, Page 1
Brief Statement	§4306(m)	This contract or policy contains a brief description of the contract on its first page.	IND003, Page 1
Table of Contents Model Language Used? Yes ☒ No ☐	§3102(c)(1)(G) Model Language	A table of contents is required.	IND003, Page 2
DEFINITIONS Model Language Used? Yes ☒ No ☐	§ 3217 Model Language	*For a complete listing of the definitions click on the adjacent Model Language link.*	Form/Page/Para Reference
Services Performed at Comprehensive Care Center for Eating Disorders	§4303(dd) §4328	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	IND003, Page 5, Sec 1, Para 6
HOW THIS COVERAGE			Form/Page/Para

WORKS			Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ☒ No ☐	§3217-a(a)(9) §3217-a(a)(10) §4324(a)(9); (10) PHL § 4408(1)(i) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	
Designation of Primary Care 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.	IND003, Page 9, Sec 2.3-2.4
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.	IND003, Page 9, Sec 2.4
Preauthorization			
Preauthorization Requirements Model Language Used? Yes ☒ No ☐	§3217-a(a)(2) §3238 §4324(a)(1) PHL § 4408(1)(b) Model Language	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for In-Network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or $500.00, whichever is less, is permissible.	Not Applicable
Medical Necessity			
Definition of Medical Necessity Model Language Used?	§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.	IND003, Page 9, Sec 2.5-2.7

Yes ☒ No ☐			
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.	IND003, Page 11, Sec 2.10
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.	IND003, Page 12, Sec 3.1
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.	Not Applicable
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.	Not Applicable
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.	Not Applicable
Transitional Care When A Provider Leaves the Network Model Language Used? Yes ☒ No ☐	§4804(e) §3217-d(c) §4306-C(c) PHL §4403(6)(e) Model Language	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to ninety (90) days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee	IND003, Page 12, Sec 3.2

		that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
Transitional Care For A New Member in a Course of Treatment Model Language Used? Yes ☒ No ☐	§4804(f) §3217-d(c) §4306-C(c) PHL §4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (1) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (2) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to sixty (60) days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	IND003, Page 12, Sec 3.3
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.	IND003, Page 13, Sec 4.2
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.	IND003, Page 13, Sec 4.6
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes ☒ No ☐	§3217-a(a)(6) §4324(a)(6) PHL §4408(1)(f) Model Language	This policy or contract form includes a description of the insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	IND003, Page 1, Para 3
ELIGIBILITY Model Language Used? Yes ☒ No ☐	Model Language		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.	ND003, Page 15, Sec 5.1
Spouse	§4304(d) Circular Letter No. 27 (2008) Model Language	For Spouse and/or Family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex spouses legally performed in this state and in other jurisdictions.	IND003, Page 15, Sec 5.2I
Dependents	§4304(d) §3216(a)(3) §3216(a)(4) 42 USC §300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of children until age 26. *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.*	IND003, Page 15, Sec 5.2-5.3
Unmarried Disabled Children	§4304(d) §3216(a)(4)(C) Model Language	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *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.*	IND003, Page 14, Sec 5.3
Newborn Infants	§4304(d) §3216(c)(4)(C) Model Language 45 C.F.R. § 155.420 45 C.F.R. § 155.725	For Parent and Child/Children and/or Family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 60 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of Individual or Individual and Spouse Coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium are required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 60 days of the day of birth to make coverage effective from the moment of birth.*	IND003, Page 16, Sec 5.5
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	IND003, Page 15, Sec 5.3

		during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners	§4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • 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.	IND003, Page 17, Sec 5.6
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.	IND003, Page 15, Sec 5.4-5.5
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	**Except where noted below, the following benefits must be included in the policy or contract form.** 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, as well as DFS review. The categories of benefits that may be substituted are: A. Preventive/Wellness/Chronic Disease Management B. Rehabilitative and Habilitative	Form/Page/Para Reference
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.	IND003, Page 19, Sec 6.1.1
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.	IND003, Page 19, Sec 6.1
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.	IND003, Page 20, Sec 6.1.4
Mammography Screening Model Language Used? Yes ☒ No ☐	§4328 §3216(i)(11) §4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language	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.	IND003, Page 20, Sec 6.1.5

	HRSA Guidelines	• An annual mammogram for covered persons aged 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	
Family Planning & Reproductive Health Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines §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.	IND003, Page 20, Sec 6.1.6
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 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	IND003, Page 20, Sec 6.1.7
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.	IND003, Page 21, Sec 6.1.8

		Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
EMERGENCY SERVICES AND URGENT CARE			
Pre-Hospital Emergency Medical and Ambulance Services Model Language Used? Yes ☒ No ☐	§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: • 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.	IND003, Page 21, Sec 6.2, 6.2.1, 6.2.2
Emergency Services Model Language Used? Yes ☒ No ☐	§4328 §4303(a)(2) §3216(i)(9) §3217-a(a)(8) §4900(c) §4303(a)(2) Circular Letter No.1	This policy or contract form includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers;	IND003, Page 22, Sec 6.3

	(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	• the cost-sharing (copayment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *Note the following definitions must be used:* *Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii)serious dysfunction of any bodily organ or part of such person; or (iv)serious disfigurement of such person; or a condition described in §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).*	
Urgent Care Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §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.	IND003, Page 24, Sec 6.4
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging	45 CFR § 156.100 §4328	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans.	IND003, Page 24, Sec 6.5.2

Model Language Used? Yes ☒ No ☐	§3216(l) Model Language	Such coverage may be subject to deductibles, copayments and/or coinsurance.	
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.	IND003, Page 25, Sec 6.5.3
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.	IND003, Page 25, Sec 6.5.4
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.	IND003, Page 25, Sec 6.5.5
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 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.*	IND003, Page 25, Sec 6.5.6

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.	IND003, Page 25, Sec 6.5.7
Outpatient Habilitative Services Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☒ No ☐ Are additional benefits being added to this EHB category? Yes ☒ No ☐ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	§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.	IND003, Page 25, Sec 6.5.8
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.	
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 and may provide coverage that is more favorable.*	IND003, Page 26, Sec 6.5.10
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. 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:	IND003, Page 26, Sec 6.5.11

		in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; cost for an ovum donor or donor sperm; sperm storage costs; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	
Infusion Therapy Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §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.	IND003, Page 27, Sec 6.5.12
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.	IND003, Page 27, Sec 6.5.13
Office Visits Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) Model Language	This policy or contract form provides coverage for office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IND003, Page 27, Sec 6.5.16
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.	IND003, Page 27, Sec 6.5.17
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.	IND003, Page 27, Sec 6.5.18
Outpatient Rehabilitative Services	45 CFR § 156.100 §4328 §3216(l)	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.	IND003, Page 28, Sec 6.5.19

Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Standard benefit in the space provided.	Model Language	*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: plans may: increase the number of covered visits; cover 60 or more visits per therapy or condition; cover visits per year rather than per condition; remove the lifetime limit; remove the other conditions/ limitations for coverage; and/or omit the requirement for a prior hospitalization or surgery.*	
Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ☒ No ☐	§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.	IND003, Page 28, Sec 6.5.20

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.	IND003, Page 28, Sec 6.5.20
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.	IND003, Page 28, Sec 6.5.20
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.	IND003, Page 28, Sec 6.5.20
Surgical Services Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §4328 §3216(l) 11 NYCRR § 52.6 Model Language	This policy or contract form includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IND003, Page 28, Sec 6.5.21
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.	IND003, Page 29, Sec 6.5.22
Mastectomy Care	§3216(l)	This policy or contract form includes coverage for a period of inpatient hospital care as is determined	

Model Language Used? Yes ☒ No ☐	§3216(i)(20) §4328 §4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	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.	IND003, Page 36, Sec 6.8.5
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.	IND003, Page 29, Sec 6.5.24
Transplants Model Language Used? Yes ☒ No ☐	45 CFR § 156.100 §3215(l) §4328 Model Language	This policy or contract form provides coverage for transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	IND003, Page 29, Sec 6.5.25
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).	IND003, Page 30, Sec 6.6.1

		The policy or contract form shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis is limited to 680 hours per covered individual per year. The policy or contract form shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☒ No ☐	§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: Plans may apply 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.*	IND003, Page 32, Sec 6.6.2-6.6.5
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.	IND003, Page 33, Sec 6.6.6-6.6.8
Hearing Aids Model Language Used?	45 CFR § 156.100 §4328 §3216(l)	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	IND003, Page 33, Sec 6.6.9

Yes ☒ No ☐	Model Language	into the ear. A hearing aid consists of a microphone, amplifier and receiver. Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years. *{Note: The three year limit on hearing aids is required for plans but the limit may be removed or modified so that coverage is more favorable.}* Bone anchored hearing aids must be covered only if an insured has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Coverage must be provided for one hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. *{Drafting Note: The limit on hearing aids is required for plans but this limit may be removed or modified so that coverage is more favorable.}* Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospice Care Model Language Used? Yes ☒ No ☐	§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: A plan must cover 210 days of hospice care; however plans can cover more than 210 days.*	IND003, Page 34, Sec 6.6.10
Prosthetics	45 CFR § 156.100 §3216(l)	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	IND003, Page 34, Sec 6.7

Model Language Used? Yes ☒ No ☐	§4328 Model Language	external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one external prosthetic device per limb per lifetime. Replacements are covered for children for devices that have been outgrown. *Note: The limit on prosthetic devices is required for plans, but the limit may be removed for modified so that coverage is more favorable.* Internal Prosthetic Devices**:** This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospital Services Model Language Used? Yes ☒ No ☐	11NYCRR§52.5 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.	IND003, Page 35, Sec 6.8.1
Maternity Care	§3216(i)(10) §4328	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	IND003, Page 36, Sec 6.8.4

Model Language Used? Yes ☒ No ☐	4303(c) Model Language	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. 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.	IND003, Page 36, Sec 6.8.6
Inpatient Rehabilitative Services Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒ Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition	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: Plans must cover 60 days; however plans may exceed the required 60 days, and also may remove the "per condition" and/or "per lifetime" limit.* Such coverage may be subject to deductibles, copayments and/or coinsurance. *For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.*	IND003, Page 36, Sec 6.8.7

differs from the Model Language in the space provided.			
Benefit explanation:			
Skilled Nursing Facility Model Language Used? Yes ☒ No ☐	§3216(i)(6) §4328 §4303(d) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, for up to 200 days, per Calendar Year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. *Note: Plans must cover 200 days, but may cover more than 200 days.* Such coverage may be subject to deductibles, copayments and/or coinsurance.	IND003, Page 36, Sec 6.8.8
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.	IND003, Page 37, Sec 6.8.9
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.*	IND003, Page 37, Sec 6.9.1, A
Outpatient Mental Health Care Services	§3216(i)(4) §4328	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	IND003, Page 37, Sec 6.9.1, B

Model Language Used? Yes ☒ No ☐	§4303(g) §4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	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. 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.*	IND003, Page 38, Sec 6.9.2, A

Outpatient Substance Use Services Model Language Used? Yes ☒ No ☐	§3216(l) §4328 §4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 45 CFR § 156.100 Model Language	This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opiod addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for Substance Use, and/or Dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.* *Under MHPAEA, 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.*	IND003, Page 38, Sec 6.9.2, B
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 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.	IND003, Page 37, Sec 6.10.1
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.	IND003, Page 39, Sec 6.10.1
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.	IND003, Page 39, Sec 6.10.1
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.	IND003, Page 40, Sec 6.10.3 B
Prohibition for Tier IV Drugs	§4328 §3216(l)	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	IND003, Page 40, 6.10.3 A

	§4303(gg) PHL §4406-c(7)	brand drugs if there is no non-preferred brand drug category).	
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 limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	IND003, Page 40, 6.10.2
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.	IND003, Page 39, Sec 6.10.1
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.	IND003, Page 41, Sec 6.10.3, E
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.*	IND003, Page 39, Sec 6.10.1, 6.10.3 D
WELLNESS	45 CFR § 156.100 §3239		
Exercise Facility Reimbursement Model Language Used? Yes ☒ No ☐ Is this benefit being substituted? Yes ☐ No ☒	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: Plans may offer more comprehensive coverage or may substitute this benefit.*	IND003, Page 46, Sec 6.11

Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239. Are additional benefits being added to this EHB category? Yes ☐ No ☒ If yes, please explain how this substitution or addition differs from the Model Language in the space provided.			
Benefit explanation:			
Other Wellness Benefits	45 CFR § 156.100 §3239 §4328 §3216(l)	Additional Wellness Benefits may be covered. All additional wellness benefits must comply with § 3239 of Insurance Law.	Not Applicable
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.	IND003, Page 47, Sec 6.12
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes ☐ No ☐ Is dental coverage being provided by this filing? Yes ☐ No ☐ If No, please provide	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. *Note: Insurers are required to offer the pediatric dental essential health benefit as either an embedded benefit (coverage provided by the insurer) or bundled benefit (coverage provided through an arrangement with another insurer).*	

information in the explanation box below as to how the insurer is meeting the requirement to offer the pediatric essential health benefit.		*Embedded pediatric dental benefits must comply with all of the market reform and rating rules such guaranteed availability, rating tiers, rating regions, etc. For rating purposes, the pediatric dental benefit would be included in the insurer's single risk pool, medical loss ratio calculations and actuarial value calculations. Expenses related to an embedded pediatric dental benefit must also be included as part of the calculation of deductibles and out of pocket expense maximums.* *If the insurer offers a bundled stand-alone pediatric dental benefit, the following conditions must all be met:* *• The bundled dental benefit is identical to a stand-alone dental plan offered by the same dental carrier that is certified by the Exchange but offered outside the Exchange, including at the same premiums;* *• The policyholder or contractholder is informed that the dental benefit is being offered by a separate insurer, even if only one issuer collects the premiums;* *• The policyholder or contractholder is clearly informed of the medical plan design and the dental plan design and that the two plan designs have different deductibles, cost sharing and OOP maximums;* *• The policyholder or contractholder is clearly informed that they can purchase any stand-alone dental plan, other than the bundled dental plan, that has been certified by the Exchange but offered outside the Exchange.* *• The pediatric dental benefit meets the 70% or 85% actuarial value and $700 OOP maximum for one covered child (or $1,400 if more than one child in the family is covered);* *• The stand alone dental plan complies with all ACA provisions and CMS regulations pertaining to stand alone dental plans;* *• Insurers should specifically describe the legal and business arrangement between the medical issuer and the dental issuer when submitting the forms and rates to DFS, and each insurer must separately submit its own forms and rates for approval.* *If the insurer is reasonably assured that an individual has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange the insurer does not need to provide the dental benefit when coverage is issued. Insurers may include a question in their application/enrollment form in order to verify whether an insured has obtained stand-alone pediatric dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange*	
Explanation:			

ADDITIONAL BENEFITS			
Family Vision Model Language Used? Yes ☐ No ☒	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one vision examination in any twelve (12) month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses & frames; and contact lenses.	Not Applicable
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.	Not Applicable
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.	
MAKE AVAILABLE BENEFITS			
Care in a Nursing Home or Skilled Nursing Facility	§ 3216(j) § 4303(d)	This policy or contract must make available coverage for care in a nursing home, as defined by Public Health Law §2801, or a skilled nursing facility as defined in 42 USC §§1395, when such services are preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.	IND003, pg. 36, Sec. 6.8.8
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?	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.	IND003, Page 48, Sec 7.1

Yes ☐ No ☐			
Convalescent and Custodial Care Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.	IND003, Page 48, Sec 7.2
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.	IND003, Page 48, Sec 7.3
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.	IND003, Page 48, Sec 7.4
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.	IND003, Page 48, Sec 7.5
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.	IND003, Page 48, Sec 7.6
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.	IND003, Page 48, Sec 7.7
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.	IND003, Page 49, Sec 7.8
Government Facility Model Language Used?	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.	IND003, Page 49, Sec 7.9

Yes ☒ No ☐			
Medically Necessary Model Language Used? Yes ☒ No ☐	§3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an External Appeal Agent certified by the State.	IND003, Page 49, Sec 7.10
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).	IND003, Page 49, Sec 7.11
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.	IND003, Page 49, Sec 7.12
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.	IND003, Page 49, Sec 7.13
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.	IND003, Page 49, Sec 7.14
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.	IND003, Page 49, Sec 7.15
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.	IND003, Page 49, Sec 7.16
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.	IND003, Page 49, Sec 7.17
Vision Services	11NYCRR52.16(c)(10)	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.	IND003, Page 49, Sec 7.18

Model Language Used? Yes ☒ No ☐	Model Language		
Workers' Compensation Model Language Used? Yes ☒ No ☐	11NYCRR52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	IND003, Page 50, Sec 7.19
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.	IND003, Page 50, Sec 7.20
CLAIM DETERMINATION			Form/Page/Para Reference
Notice of Claim	§3216(d)(1)(E) Model Language	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	IND003, Page 51, Sec 8.1-8.2
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.	IND003, Page 51, Sec 8.3
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.	IND003, Page 53, Sec 9.1
Utilization Review Policies and Procedures	§3217-a(a)(3) §4324(a)(3) Article 49	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;	IND003, Page 55, Sec 9.2

Model Language Used? Yes ☒ No ☐	PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	• the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; • the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	
External Appeal Procedures Model Language Used? Yes ☒ No ☐	Article 49 PHL Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	This policy or contract form includes a description of the external appeal procedures, including: • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued (service denied as not medically necessary; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), and HMOs, out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal.	IND003, Page 57, Sec I-V
COORDINATION OF BENEFITS Model Language Used? Yes ☒ No ☐	11 NYCRR 52.23 Model Language	If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	Form/Page/Para Reference
TERMINATION OF COVERAGE Model Language Used? Yes ☒ No ☐	Model Language §4306(c) §4304(c)	*The following are the only termination provisions permissible under the Insurance Law.*	Form/Page/Para Reference
Notice of Termination	11 NYCRR 52.17	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	IND003, Page 61, Sec 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.	IND003, Page 61, Sec 3a
Reinstatement Following Default	§4306(g) §3216(d)(1)(D)	Contracts 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	IND003, Page 66, Sec 19

		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.	IND003, Page 61, Sec 3b
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.	IND003, Page 61, Sec 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.	IND003, Page 61, Sec 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.	IND003, Page 61, Sec 3c
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.	IND003, Page 61, Sec 1b
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.	IND003, Page 61, Sec 1a
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.	IND003, Page 61, Sec 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.	IND003, Page 61, Sec 3b
Renewal	§3216(g) §4304(b)(2) 11 NYCRR	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.	IND003, Page 66, Sec 18

	52.17(a)(2)	The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	
Premiums	§4306(a) §3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the subscriber or such other person designated, by the due date, with a grace period as specified.	IND003, Page 65, Sec. 15
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes ☒ No ☐	11 NYCRR 52.17(a)(15) Model Language	If the covered persons' coverage terminates, an extended benefit will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability.	IND003, Page 62, Sec. 11.1
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.	IND003, Page 63, Sec. 11.2.4
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.	IND003, Page 62, Sec. 11.2
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.	IND003, Page 64, Sec. 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.	IND003, Page 67, Sec. 29
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.	IND003, Page 67, Sec. 25
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).	IND003, Page 64, Sec. 24
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.	IND003, Page 67, Sec. 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.	IND003, Page 67, Sec. 26
SCHEDULE OF BENEFITS Model Language Used? Yes ☒ No ☐	Model Language	This policy or contract must contain a Schedule of Benefits. All services subject to preauthorization must be clearly indicated in the Schedule of Benefits.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☒ No ☐	§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.	Schedule of benefits
Limitations on Annual	§4328	The policy or contract form may not impose "restricted" annual dollar limits for essential health	

Dollar Limits Model Language Used? Yes ☒ No ☐	§3217-f §4306-e 42 USC §300gg-11 45 CFR §147.126 Model Language	benefits.	Schedule of benefits
Insured's Financial Responsibility for Payment	§3217-a(a)(5) §4324(a)(5) PHL §4408(1)(e)	This policy or contract form includes a description of the insured's financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	Schedule of benefits
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.*	N/A
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).	See Rider: FHSC -WMBT001
PROVIDER NETWORKS Has network been submitted to and/or approved by the Department of Health or the Exchange? Yes ☒ No ☐ If yes, please indicate the name of the network, the	§3201(c)	If the insurance (other than HMO) policy or contract will be used in conjunction with a provider network, please identify in the adjacent box whether the insurer is using the same network that was submitted to and/or approved by the Department of Health and/or the Exchange. Please indicate the network name and network ID number and include the date that the network was submitted to and/or approved by the Department of Health and/or the Exchange. If the network differs in any respect from that which was submitted to and/or approved by the Department of Health and/or the Exchange, please provide details on how the network differs in the Supporting Documentation Tab in SERFF. This includes, but is not limited to, detailing the providers and specialty types in each county that differ from the network that was submitted to and/or approved	

network ID number, and the dates that the network was submitted to and/or approved by the Department of Health or the Exchange. Network Name: Network ID #: Date Submitted: Date Approved:		by the Department of Health and/or the Exchange . In addition, the following items or information must be submitted as part of this filing: • Participating provider directory; • Whether the provider network is capitated; • Provider selection criteria; • Quality assurance procedures; • Breakdown of geographic service area by county; • The underlying assumptions for the network regarding ratios of providers to insureds, the travel times and distances to participating providers; • Sample participating provider agreement; and, • Listing of providers by specialty type by county. *Note: The Department will not permit more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.*	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		**PLEASE NOTE: A new and detailed set of instructions "Instructions for the Submission of 2014 Premium Rates for 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 82.4 %.	See actuarial memo.

Loss Ratios	§3231(e)(1)(B) §4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification	See actuarial memo.
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	All manual rates developed on
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.	See actuarial memo.
Expected Loss Ratio Certification	§3231(e)(1)(B) §4308(c)(3)(A)	The expected loss ratio is: 82.4 %.	See actuarial memo.
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.)*	F
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or Member of the American Academy of Actuaries; and 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).	

Name of Company: Freelancers Health Service Corporation.
This is to certify that the forms listed on the attached page(s) are in compliance with New York=s Insurance Policy Readability Law.

A. Option Selected.

[ ] 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is ___.

[x] 2. Policy and its related forms are scored separately for the Flesch reading east test. Scores for the policy and each form are indicated on the attached page(s).

B. Test Option Selected

[x] 1. Test was applied to entire policy form(s).

[ ] 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards of Certification

A checked block indicates the standard has been achieved.

[ ] 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above. The policy text does not achieve a minimum score of 45. However, we request that the Department accept the lower score as the policy text is identical to model language provided by the Department.

[x] 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables.)

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

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

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

[x] 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

[x] 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

[ ] 8.

[redacted]

[redacted]
Officer's Title

Date: April 26, 2013

Freelancers Health Service Corporation

Flesch Scores for the forms submitted with this filing are:

Form #	Sentences	Words	Syllables	Flesch Score
FHSC-WMBT003	7	483	1.67	39.3
FHSC-CAT001	1,094	32,813	1.66	43.7
FHSC-CHILD001	1,086	31,802	1.67	43.1
FHSC-IND002	1,132	32,101	1.68	43.9
FHSC-SHOP002	1,175	35,490	1.67	44.1
FHSC-GPCON001	107	3,509	1.53	48.2
FHSC-IND001	1,158	32,271	1.68	43.8
FHSC-SHOP001	1,167	34,914	1.67	44.2
FHSC-WMBT002	14	290	1.82	40.4
FHSC-WMBT001	6	190	1.54	47.8

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Freelancers Health Service Corporation
Memorandum of Variable Information
Individual Contract, Form #FHSC-IND003
Off-Exchange Standard and Non-Standard Plans

Description	Variation
Cover Page: the brackets allow the plan to change the address of the Health Plan/issuer. Any such change would apply to all contracts.	[112 West 34th Street, Suite 17058, New York, New York 10120]
Definitions, Participating Providers: the brackets allow the plan to change the name of the website/URL. Any such change would apply to all contracts.	[www.newyorkcoop.org]
Section II, paragraph 2.3: the brackets allow the plan to change the name of the website/URL. Any such change would apply to all contracts.	[www.newyorkcoop.org]
Section II, paragraph 2.10, Claims: the brackets allow the plan to change the address where claims must be mailed.	[P.O. Box 6329, Syracuse, New York 13217-6329]
Section II, paragraph 2.10, Complaints, Grievances, and Utilization Reviews: the brackets allow the plan to change the address to where complaints, grievances, and UR reviews must be sent. Any such change would be applied to all contracts.	[2425 James St., Syracuse, NY 13206]
Section II, paragraph 2.10, Complaints, Grievances, and Utilization Reviews: the brackets allow the plan to change the phone number for complaints, grievances, and UR reviews must be sent. Any such change would be applied to all contracts.	[315.432.9171]
Section II, paragraph 2.10, Complaints, Grievances, and Utilization Reviews: the brackets allow the plan to change the fax number for complaints, grievances, and UR reviews must be sent. Any such change would be applied to all contracts.	[315.432.9442 or 315.432.1689]
Section II, paragraph 2.10, Medical Emergencies and Urgent Care: the brackets allow the plan to change the phone number for emergencies and urgent care. Any such change would be applied to all contracts.	[315.432.9171]
Section II, paragraph 2.10, Medical Emergencies and Urgent Care: the brackets allow the plan to change the fax numbers for emergencies and urgent care. Any such change would be applied to all contracts.	[315.432.9442 or 315.432.1689]
Section II, paragraph 2.10, Medical Emergencies and Urgent Care: the brackets allow the plan to change the phone numbers for emergencies and urgent care occuring on evenings, weekends or holidays. Any such change would be applied to all contracts.	[315.432.9171 or 1.800.934.2459]
Section II, paragraph 2.10, Member Services: the brackets allow the plan to change the days and hours that Member Services is availabie and can be reached. Any such change would be applied to all contracts.	[Monday – Friday 8:00 a.m. – 5:00 p.m.]

Section II, paragraph 2.10, Member Services: the brackets allow the plan to change the phone number for Member Services. Any such change would be applied to all contracts.	[315.432.9171]
Section II, paragraph 2.10, Preauthorization: the brackets allow the plan to change the days and hours when calls can be made for preauthorization. Any such change would be applied to all contracts.	[Monday - Friday, 8:00 a.m. - 6:00 p.m. EST]
Section II, paragraph 2.10, Preauthorization: the brackets allow the plan to change the phone numbers for preauthorization. Any such change would be applied to all contracts.	[1.800.766.2648 or 315.437.9518]
Section II, paragraph 2.10, Preauthorization: the brackets allow the plan to change the fax numbers for preauthorization. Any such change would be applied to all contracts.	[315.463.1483]
Section II, paragraph 2.10, Our Website: the brackets allow the plan to change the company's website/URL. Any such change would be applied to all contracts.	[www.newyorkcoop.org]
Section VI, paragraph 6.1, Preventive Care: the brackets allow the plan to change the phone number to call to receive comprehensive guidelines. Any such change would be applies to all contracts.	[315.432.9171]
Section VI, paragraph 6.1, Preventive Care: the brackets allow the plan to change the website to visit to receive comprehensive guidelines. Any such change would be applies to all contracts.	[www.newyorkcoop.org]
Section VI, 6.1.3, Adult Annual Physical Examinations: the brackets allow the plan to change the website to obtain a list of covered preventive services. Any such change would be applied to all contracts.	[www.newyorkcoop.org]
Section VI, 6.1.5, Well-Woman Examinations: the brackets allow the plan to change the website to obtain a list of covered preventive services. Any such change would be applied to all contracts.	[www.newyorkcoop.org]
Section VI, 6.5.1, Outpatient and Professional Services, Acupuncture: the brackets allow the plan to include Acupunture benefits in non-standard plans.	[6.4.1 Acupuncture. We cover acupuncture services (only for non-standard plans).]
Section VI, Prescription Drugs, 6.10.1: the brackets allow the plan to change the website URL where the formulary can be viewed. Any such change will be applied to all contracts.	[www.newyorkcoop.org]
Section VI, Prescription Drugs, 6.10.3b: the brackets allow the plan to change the telephone numbers used to obtain prescription drug claim forms. Any such change will be applied to all contracts.	[1.800.766.2648 or 315.437.9518]
Section VI, Prescription Drugs, 6.10.3b: the brackets allow the plan to change the website/url used to obtain prescription drug claim forms. Any such change will be applied to all contracts.	[www.newyorkcoop.org]

Section VI, Prescription Drugs, 6.10.3e: the brackets allow the plan to change the website/url used to obtain a list of prescriptions available through mail order. Any such change will be applied to all contracts.	[www.newyorkcoop.org]
Section VI, Prescription Drugs, 6.10.3h: the brackets allow the plan to change the website/url used to access a list of maximum quantity levels for certain prescription drugs. Any such change will be applied to all contracts.	[www.newyorkcoop.org]
Section VI, Prescription Drugs, 6.10.4: the brackets allow the plan to change the website/url used to access a list of prescription drugs that require preauthorization. Any such change will be applied to all contracts.	[www.newyorkcoop.org]
Section VI, Prescription Drugs, 6.10.4c: the brackets allow the plan to change the website/url used to access a list of therapeutic substitution drugs. Any such change will be applied to all contracts.	[www.newyorkcoop.org]
Section VI, Prescription Drugs, 6.10.7: the brackets allow the plan to change the website/url used to access information concerning which tier a drug has been assigned to. Any such change will be applied to all contracts.	[www.newyorkcoop.org]
Section IX, 9.1.1, Filing A Grievance: the brackets allow the plan to change the phone numbers used to file a grievance. Any such change will be applied to all plans.	[www.newyorkcoop.org]
Section XII, 12.14, Notice: the brackets allow the plan to change the address that is used by the health plan to receive and accept Notice. Any such change will be applied to all plans.	[112 West 34th Street, Suite 17058, New York, New York 10120].
Section Xiii, 13.26, Translation Services: the brackets allow the plan to change the phone number used to accept inquiries concerning translantion services. Any such change will be applied to all plans.	[315.432.9171]
Schedule Of Benefits: the brackets allow the plan to provide the appropriate detailed description of cost-sharing and benefit limits to the Certificate holder.	[EssentialCare Bronze] [EssentialCare Silver 1] [EssentialCare Silver 2] [EssentialCare Silver 3] [EssentialCare Silver 4][EssentialCare Gold] [EssentialCare Platinum] [EssentialCare American Indian Alaska Native][Primary Select Bronze] [Primary Select Silver 1][Primary Select Silver 2] [Primary Select Silver 3] [Primary Select Silver 4] [Primary Select Gold] [Primary Select Platinum]
RIDER TO EXTEND COVERAGE FOR YOUNG ADULTS THROUGH AGE 29: the brackets allow the plan to include the Rider as appropriate.	[RIDER TO EXTEND COVERAGE FOR YOUNG ADULTS THROUGH AGE 29]

This is Your

EXCLUSIVE PROVIDER ORGANIZATION CONTRACT

Issued by

Freelancers Health Service Corporation
DBA Health Republic Insurance of New York
30 Broad Street 34th Floor New York, New York 10004

This is Your individual direct payment Contract for exclusive provider organization coverage issued by Freelancers Health Service Corporation DBA Health Republic Insurance of New York. This Contract, together with the attached Schedule of Benefits, applications, and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid, including any Contract fees or other charges.

In-Network Benefits. This Contract only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our MagnaCare[sm] Extra Network. Except for care for an Emergency Condition described in Section VI, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

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

Signed B [redacted]

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SECTION I. DEFINITIONS

Defined terms will appear capitalized throughout the Contract.

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

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See Section VI of this Contract for a description of how the Allowed Amount is calculated.

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

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

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

Catastrophic Coverage: Coverage offered in the individual market that meets the following requirements:

- Does not provide bronze, silver, gold or platinum level of coverage;
- Covers the essential health benefits once the Deductible is reached;
- Covers at least three primary care visits per Plan Year before reaching the Deductible; and
- Covers only persons who meet the eligibility requirements as described in the "Who Is Covered" Section.

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

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

Contract: This Contract issued by Freelancers Health Service Corporation DBA Health Republic Insurance of New York, including the Schedule of Benefits and any attached riders.

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

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

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

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered

Services. You may also have a Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

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

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Is appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

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

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

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

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

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

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

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

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

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

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

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

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of United States Public Law 89-97 (42 U.S.C. § 1395x(k));
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

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

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

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

Medically Necessary: See Section II of this Contract for the definition.

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

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

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

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

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at http://newyork.healthrepublic.us/network or upon Your request to Us. The list will be revised from time to time by Us.

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

Plan Year: A 12-month calendar year.

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

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

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

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

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

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

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

Service Area: The geographical area designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties: Albany, Bronx, Brooklyn,

Chautauqua, Columbia, Delaware, Dutchess, Erie, Essex, Greene, Hamilton, Monroe, Nassau, New York, Niagara, Onandaga, Ontario, Orange, Orleans, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Staten Island, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester.

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

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

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

Subscriber: The person to whom this Contract is issued.

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

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

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

Us, We, Our: Freelancers Health Service Corporation DBA Health Republic Insurance of New York and anyone to whom We legally delegate to perform, on Our behalf, under the Contract.

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

You, Your: The Member.

SECTION II. HOW YOUR COVERAGE WORKS

2.1 Your Coverage under this Contract

You have purchased a Freelancers Health Service Corporation DBA Health Republic Insurance of New York Contract from Us. We will provide the benefits described in this Contract to You and Your Covered Dependents. You should keep this Contract with Your other important papers so that it is available for Your future reference.

2.2 Covered Services

You will receive Covered Services under the terms and conditions of this Contract only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits in Section XIII of this Contract; and
- Received while Your Contract is in force.

2.3 Participating Providers

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request.
- Call Member Services.
- Visit our website http://newyork.healthrepublic.us/.

2.4 The Role of Primary Care Physicians

This Contract does not have a gatekeeper, usually known as a Primary Care Physician (PCP). You do not need a written Referral from a PCP before receiving Specialist care from a Participating Provider. You may visit any Participating PCP who is available from the list of PCPs in the EPO MagnaCare^{sm} Extra Network. For purposes of Cost-Sharing, if You seek services from a Primary Care Physician (or a Physician covering for a Primary Care Physician) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits in section XIII of this Contract.

However, You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits in Section XIII of this Contract for the services that require Preauthorization.

2.5 Services Subject To Preauthorization

Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network services listed in the Schedule of Benefits in Section XIII of this Contract.

2.6 Preauthorization/Notification Procedure

If You seek coverage for services that require Preauthorization or notification, You must call Us at the number indicated on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least two weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then during regular business hours prior to the admission.

- At least two weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in a free standing Ambulatory Surgical Center.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

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

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

2.7 Failure to Seek Preauthorization or Provide Notification

If You fail to seek Our Preauthorization or provide notification for benefits subject to this Section, We will pay an amount $500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

2.8 Medical Management

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

2.9 Care Must Be Medically Necessary

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

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

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;

- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

  See Section IX of this Contract for Your right to an internal appeal and external appeal of Our determination that a service is not Medically Necessary.

2.10 Important Telephone Numbers and Addresses

CLAIMS
*Submit claim forms to this address.
Health Republic Insurance of New York
P.O. Box 6329
Syracuse, NY 13217-6329

COMPLAINTS, GRIEVANCES, AND UTILIZATION REVIEW APPEALS
Health Republic Insurance of New York
2425 James Street
Syracuse, NY 13206
Phone: 888.990.5702
Fax: 315-433-5445

MEMBER SERVICES
* Member Services Representatives are available Monday – Friday 8:30 a.m. – 5:30 p.m. EST
Phone: 888.990.5702
Fax: 315-432-9442

PREAUTHORIZATION
Monday – Friday 8:00 a.m. – 6:00 p.m. EST
Phone: 888.990.5702
Fax: 315-433-5442

OUR WEBSITE
http://newyork.healthrepublic.us

SECTION III. ACCESS TO CARE AND TRANSITIONAL CARE

3.1 Referral to a Non-Participating Provider

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

3.2 When Your Provider Leaves the Network

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

In order for You to continue to receive Covered Services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients, or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

3.3 New Members In a Course of Treatment

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

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

SECTION IV. COST-SHARING EXPENSES AND ALLOWED AMOUNT

4.1 Deductible

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

4.2 Copayments

Except where stated otherwise, after You have satisfied the annual Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits in Section XIII of this Contract for Covered in-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

4.3 Coinsurance

Except where stated otherwise, after You have satisfied the annual Deductible as described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network benefit as shown in the Schedule of Benefits in Section XIII of this Contract.

4.4 Primary Care; Office Visit Allowance

We Cover Services provided in an office setting for diagnostic evaluation and treatment in full for each Member until the allowance described in the Schedule of Benefits in Section XIII of this Contract is exhausted for a Plan Year. Once the allowance is exhausted, the Cost-Sharing in the Schedule of Benefits will apply. Services included in the allowance are those provided by Your Primary Care Physician or Your Primary Care Physician whose specialty is exclusively internal medicine, family practice, general practice, OB/GYN, or pediatrics.

Preventive services required to be covered at no Cost-Sharing do not count towards the allowance.

4.5 Out-of-Pocket Limit

When You have met Your Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits in Section XIII of this Contract, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If other than Individual coverage applies, when members of the same family covered under this Contract have collectively met the family Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year.

4.6 Allowed Amount

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

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

See Section VI of the Contract for the Allowed Amount for an Emergency Condition.

SECTION V. WHO IS COVERED

5.1 Who Is Covered Under This Contract

You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live, work, or reside in Our Service Area to be covered under this Contract. If You are eligible for Medicare, You are not eligible to purchase this Contract. This Contract provides Catastrophic Coverage only. In order to be eligible for Catastrophic Coverage, You, the Subscriber must also be:

- Under the age of 30 at the beginning of the Plan Year; or
- Exempt from the individual mandate because You cannot afford minimum essential coverage or are eligible for a hardship exception.

If You selected one of the following types of coverage, members of Your family may also be covered if the family member is:

- Under the age of 30 at the beginning of the Plan Year; or
- Exempt from the individual mandate because You cannot afford minimum essential coverage or are eligible for a hardship exception.

5.2 Types of Coverage

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

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

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

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

5.3 Children Covered Under This Contract

If You selected Parent and Child/Children or Family coverage, "Children" covered under this Contract include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

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

5.4 Open Enrollment

You can enroll under this Contract during an initial open enrollment period that runs from October 1, 2013 through March 31, 2014. If We receive Your selection between the first and fifteenth day of October, November, or December of 2013, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received by Us between the sixteenth and last day of the month of October, November or December of 2013, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then. If Your selection is received by Us between the first and fifteenth day of the month of January, February, or March of 2014, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received by US between the sixteenth and last day of the month of December 2013, January, February, or March of 2014, Your coverage will begin on the first day of the second month, as long as Your applicable premium payment is received by then.

You can enroll under this Contract during an annual open enrollment period that runs from October 15 through December 7. If We receive Your selection between these dates, Your coverage will begin on January 1 of the following year, as long as the applicable premium payment is received by then.

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

5.5 Special Enrollment Periods

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days of the occurrence of one of the following events:

- You or Your Spouse or Child loses minimum essential coverage.
- Your enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan or the Exchange.
- You adequately demonstrate to Us that another health plan in which You were enrolled substantially violated a material provision of its contract.
- You move and become eligible for new health plans;
- You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.
- You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions; or
- You, Your Spouse or Child exhausted Your COBRA or continuation coverage.

We must receive notice and We must receive any premium payment within 60 days of one of these events.

If You enroll because You lost minimum essential coverage or because You got married, Your coverage will begin on the first day of the month following Your loss of coverage or marriage.

If You have a newborn or adopted newborn Child and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth

if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have Individual or Individual and Spouse coverage You must also pay any additional premium for Parent and Child/Children or Family coverage within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise coverage begins on the date on which the We receive notice and the premium payment.

In all other cases, the effective date of Your coverage will depend on when We receive Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable premium payment is received by then.

5.6 Domestic Partner Coverage

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

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
   a. The affidavit must be notarized and must contain the following:
      - The partners are both eighteen years of age or older and are mentally competent to consent to contract.
      - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York
      - The partners have been living together on a continuous basis prior to the date of the application;
      - Neither individual has been registered as a member of another domestic partnership within the last six months; and
   b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
   c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
      - A joint bank account
      - A joint credit card or charge card
      - Joint obligation on a loan
      - Status as an authorized signatory on the partner's bank account, credit card, or charge card
      - Joint ownership of holdings or investments
      - Joint ownership of residence
      - Joint ownership of real estate other than residence
      - Listing of both partners as tenants on the lease of the shared residence
      - Shared rental payments of residence (need not be shared 50/50)
      - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence

- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
- Shared household budget for purposes of receiving government benefits
- Status of one as representative payee for the other's government benefits
- Joint ownership of major items of personal property (e.g., appliances, furniture)
- Joint ownership of a motor vehicle
- Joint responsibility for child care (e.g., school documents, guardianship)
- Shared child-care expenses, e.g. babysitting, day care, school bills (need not be shared 50/50)
- Execution of wills naming each other as executor and/or beneficiary
- Designation as beneficiary under the other's life insurance policy
- Designation as beneficiary under the other's retirement benefits account
- Mutual grant of durable power of attorney
- Mutual grant of authority to make health care decisions (e.g. health care power of attorney)
- Affidavit by creditor or other individual able to testify to partners' financial interdependence
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI. COVERED SERVICES

PREVENTIVE CARE

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

6.1 Preventive Care

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at 888.990.5702 or visit Our website at http://newyork.healthrepublic.us for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

6.1.1 Well-Baby and Well-Child Care

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

6.1.2 Adult Annual Physical Examinations

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

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening, and diabetes screening. A complete list of the Covered preventive services is available on Our website at http://newyork.healthrepublic.us, or will be mailed to You upon request.

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

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

6.1.3 Adult Immunizations

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

6.1.4 Well-Woman Examinations

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

6.1.5 Mammograms

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

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

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

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles, or Coinsurance.

6.1.6 Family Planning & Reproductive Health Services

We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug benefit in Section VI of the Contract, counseling on use of contraceptives, related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies.

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

6.1.7 Bone Mineral Density Measurements or Testing

We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to Section VI of the Contract. Bone mineral density measurements or tests, drugs, or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and

those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

6.1.8 Screening for Prostate Cancer

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

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

6.2 Pre-Hospital Emergency Medical Services and Ambulance Services

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

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

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

- Placing the health of the person afflicted with such condition or, with
- Respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or

- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable Copayment, Coinsurance, or Deductible.

Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

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

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

See the Schedule of Benefits in Section XIII of this Contract for any Preauthorization requirements for non-emergency transportation.

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

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

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

6.3 Emergency Services

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

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

We define an **Emergency Condition** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;

- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

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

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

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

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

- A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and
- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

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

6.3.1 Hospital Emergency Department Visits

In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition, as defined above, are Covered in an emergency department**. If You are uncertain whether this is the most appropriate place to receive care You can call Us before You seek treatment. Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

Follow-up care or routine care provided in a Hospital emergency department is not Covered. You should contact Us to make sure You receive the appropriate follow-up care.

6.3.2 Emergency Hospital Admissions

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

We Cover inpatient Hospital services at a Non-Participating Hospital at the In-Network Cost-Sharing for as long as Your medical condition prevents Your transfer to a Participating Hospital, unless We authorize continued treatment at the Non-Participating Hospital. If Your medical condition permits Your transfer to a Participating Hospital We will notify You and arrange the transfer. Any inpatient Hospital services received from a Non-Participating Hospital after we have notified You and arranged for a transfer to a Participating Hospital will not be Covered. See Section IX of the Contract for Your Appeal rights.

6.3.3 Payments Relating to Emergency Services Rendered

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

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

6.4 Urgent Care

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

A. In-Network

You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center.

B. Out-of-Network

We do not cover Urgent Care from Non-Participating Urgent Care Centers or Physicians in Our Service Area.

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

6.5 Outpatient and Professional Services

(For other than Mental Health and Substance Use)

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

6.5.1 Advanced Imaging Services

We Cover PET scans, MRI, nuclear medicine, and CAT scans.

6.5.2 Allergy Testing and Treatment

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

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

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

6.5.5 Chiropractic Services
We Cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation, and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Contract.

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

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

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

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

6.5.8 Home Health Care
We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical,

occupational, or speech therapy provided by the Home Health Agency, and (iv) medical supplies, drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

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

6.5.9 Interruption of Pregnancy

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

6.5.10 Infertility Treatment

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

- **Basic Infertility Services:** Basic Infertility Services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultra sound, hysterosalpingogram, sono-hystogram, testis biopsy, blood tests and medically appropriate treatment of ovulatory dysfunction. Additional tests may be Covered if the tests are determined to be Medically Necessary.
- **Comprehensive Infertility Services:** If the Basic Services do not result in increased fertility, We Cover Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.
- **Exclusions and Limitations:**
  a. In vitro, GIFT, and ZIFT procedures.
  b. Cost for an ovum donor or donor sperm.
  c. Sperm storage costs.
  d. Cryopreservation and storage of embryos.
  e. Ovulation predictor kits.
  f. Reversal of tubal ligations. Reversal of vasectomies.
  g. All costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers).
  h. Sex change procedures.
  i. Cloning.
  j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.
  k. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

6.5.11 Infusion Therapy

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

6.5.12 Laboratory Procedures, Diagnostic Testing and Radiology Services
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

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

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

6.5.14 Medications for Use in the Office: We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes.

6.5.15 Office Visits
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

6.5.16 Outpatient Hospital Services
We Cover Hospital services and supplies as described in the "Inpatient Hospital" Section that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. **Please remember**, unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

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

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

condition, per lifetime. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

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

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

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

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

6.5.19 Second Opinions

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

6.5.20 Surgical Services

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

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

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

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

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

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

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

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

6.5.24 Transplants
We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich Syndrome.

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

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient

is a Member. The medical expenses of a non-Member acting as a donor for You are not Covered if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover travel expenses, lodging, meals, or other accommodations for donors or guests. We do not Cover donor fees in connection with organ transplant surgery. We do not Cover routine harvesting and storage of stem cells from newborn cord blood.

6.6 Additional Benefits, Equipment, and Devices

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

6.6.1 Autism Spectrum Disorder

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

- **Screening and Diagnosis:** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

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

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

- **Behavioral Health Treatment:** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We

Cover applied behavior analysis when provided by an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

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

- **Psychiatric and Psychological Care**: We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.

- **Therapeutic Care:** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.

- **Pharmacy Care**: We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Contract.

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

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

Nothing in this Contract shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

6.6.2 Diabetic Equipment, Supplies and Self-Management Education

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

6.6.3 Supplies

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

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

6.6.4 Self-Management Education

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

- By a Physician, other health care provider authorized to prescribe under Title 8 of the Education Law, or their staff during an office visit;

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

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

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

6.6.7 Durable Medical Equipment
Durable Medical Equipment is equipment which is:
- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Is appropriate for use in the home.

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

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

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

6.6.9 Hearing Aids
We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

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

Bone anchored hearing aids are Covered only if You have either of the following:
- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

6.6.10 Hospice
Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

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

6.7 Prosthetics

6.7.1 External Prosthetic Devices
We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this Section of the Contract and are only covered under the pediatric vision benefit in Section VI in this Contract. We do not Cover orthotics.

For adults, We Cover the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

Coverage is for standard equipment only. We do not otherwise Cover the cost of repairs or replacement.

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

6.7.2 Internal Prosthetic Devices

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.

6.8 Inpatient Services

(For other than Mental Health and Substance Use)

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

6.8.1 Hospital Services

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

- Semiprivate room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and cystoscopic rooms and equipment;
- The use of intensive care, special care, or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

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

6.8.2 Observation Services

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

6.8.3 Inpatient Medical Services

We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Contract.

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

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

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

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

We Cover speech and physical therapy only when:

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

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

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

6.8.8 Skilled Nursing Facility
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the “Exclusions and Limitations” Section of this Contract). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 365 days, per Plan Year, for non-custodial care.

6.8.9 End of Life Care

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Contract until the External Appeal Agent renders a decision in Our favor.

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

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

6.8.10 Limitations/Terms of Coverage

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

6.9 Mental Health Care and Substance Use Services

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

6.9.1 Mental Health Care Services

A. Inpatient Services

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

B. Outpatient Services

We Cover outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such Coverage is limited to Facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental

Hygiene Law; a Facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker ~~who meets the requirements of NY Ins. Law §§ 3221(l)(4)(D), 4303(h)(1)~~; or a professional corporation or a university faculty practice corporation thereof.

C. Limitations/Terms of Coverage

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

6.9.2 Substance Use Services

A. Inpatient Services

We Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes Coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

B. Outpatient Services

We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such Coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

We also Cover up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Contract that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

6.10 Prescription Drug Coverage

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

6.10.1 Covered Outpatient Prescription Drugs

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

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

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the "Infertility" Section of this Contract.
- Off-Label Cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at http://newyork.healthrepublic.us/formulary. You may also inquire if a specific drug is Covered under this Contract by contacting us at the number on Your ID card.

6.10.2 Refills

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits in Section XIII of this Contract.

6.10.3 Benefit and Payment Information

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

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

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

   You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

2. **Participating Pharmacies:** For Prescription Drugs purchased at a retail or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug. (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at 888.990.5702 or visit our website at http://newyork.healthrepublic.us to request approval.

3. **Non-Participating Pharmacies:** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

4. **Designated Pharmacies:** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

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

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

   Following are the therapeutic classes of Prescription Drugs that are included in this program:
   - Age related macular edema
   - Anemia, neutropenia, thrombocytopenia
   - Contraceptives
   - Crohn's Disease
   - Cystic Fibrosis
   - Cytomegalovirus
   - Endocrine disorders/Neurologic disorders such as infantile spasms
   - Enzyme Deficiencies/Liposomal Storage Disorders
   - Gaucher's Disease
   - Growth Hormone
   - Hemophilia
   - Hepatitis B, Hepatitis C
   - Hereditary Angioedema
   - HIV/AIDS
   - Immune Deficiency
   - Immune Modulator
   - Infertility
   - Iron Overload
   - Iron Toxicity
   - Multiple Sclerosis
   - Oral Oncology
   - Osteoarthritis
   - Osteoporosis
   - Parkinson's Disease
   - Pulmonary Arterial Hypertension
   - Respiratory Condition
   - Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
   - Transplant
   - RSV Prevention

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

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

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

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

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at http://newyork.healthrepublic.us/formulary or by calling the Customer Service number on Your ID card. The maintenance drug list is updated periodically. Visit our website or call the Customer Service number on Your ID card to find out if a particular drug is on the maintenance list.

6. **Tier Status:** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at http://newyork.healthrepublic.us or by calling the Customer Service number on Your ID card.

7. **When a Brand-Name Drug Becomes Available As a Generic:** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in Section IX of the Contract.

8. **Supply Limits:** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply. However, for maintenance drugs we will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for one Cost-Sharing amount; up to three Cost-Sharing amounts for a 90-day supply at a retail pharmacy.

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

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at http://newyork.healthrepublic.us or by calling Customer Service at the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to Section IX of the Contract.

9. **Cost-Sharing for Orally-Administered Anti-cancer Drugs:** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits in Section XIII of this Contract or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under Section VI of this Contract.

6.10.4. Medical Management

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

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

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

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

C. **Therapeutic Substitution:** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at http://newyork.healthrepublic.us or call the Customer Service at the phone number on Your ID Card.

6.10.5 Limitations/Terms of Coverage

A. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

B. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You don't make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

C. Compounded Prescription Drugs will be Covered only when they contain at least one ingredient that is a Covered legend Prescription Drug, are Medically Necessary, and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs require You to obtain Preauthorization.

D. Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

10. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies are not Covered under this Section but are Covered under other Sections of this Contract.

11. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under Section VI of this Contract.

12. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs or as otherwise provided in this Contract.

13. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

14. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

15. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

16. Your benefit for insulin, diabetic Prescription Drugs, supplies and equipment is not provided under this Section of the Contract and is Covered under Section VI of the Contract. Your benefit for insulin and diabetic Prescription Drugs, supplies and equipment will be provided

under this Section of the Contract if the Cost-Sharing is more favorable to You under this Section of the Contract than the Cost-Sharing under Section XIII of the Contract.

17. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in Section IX of this Contract.

18. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

19. We do not Cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products except as described under the Covered Outpatient Prescription Drug Section.

6.10.6. General Conditions

A. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

B. **Drug Utilization, Cost Management, and Rebates:** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may, from time-to-time, also enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

6.10.7 DEFINITIONS

Terms used in this Section are defined as follows. (Other defined terms can be found in the "Definitions" Section of this Contract).

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

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

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

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

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

Participating Pharmacy: A pharmacy that has:

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

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

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

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

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

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

6.11 Wellness Benefits

Exercise Facility Reimbursement

We will partially reimburse the Subscriber and the Subscriber's Covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities that We have an agreement with and which maintain equipment and programs that promote cardiovascular wellness.

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

In order to be eligible for reimbursement, You must:

- Be an active member of the exercise facility, and
- Complete 50 visits in a six-month period.

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

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

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of $200 for the Subscriber and $100 for the Subscriber's Spouse or the actual cost of the membership per six-month period.

6.12 Pediatric Vision

Pediatric Vision Care

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

6.12.1 Pediatric Vision Care

We Cover emergency, preventive and routine vision care for Children up to age 19.

6.12.2 Vision Examinations

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

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

6.12.3 Prescribed Lenses & Frames

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

Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.

SECTION VII. EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Contract for the following:

7.1 Aviation

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

7.2 Convalescent and Custodial Care

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

7.3 Cosmetic Services

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

7.4 Coverage Outside of the United States, Canada or Mexico

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

7.5 Dental Services

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

7.6 Experimental or Investigational Treatment

We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Contract for non-investigational treatments. See Section IX of this Contract for a further explanation of Your Appeal rights.

7.7 Felony Participation

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

7.8 Foot Care

We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this Contract. For foot care related to diabetes, see Section VI of this Contract.

7.9 Government Facility

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

7.10 Medically Necessary

In general, We will not Cover any health care service, procedure, treatment, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State

overturns Our denial, however, We will Cover the procedure, treatment, service, or Prescription Drug for which Coverage has been denied, to the extent that such procedure, treatment, service, or Prescription Drug is otherwise Covered under the terms of this Contract.

7.11 Medicare or Other Governmental Program

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

7.12 Military Service

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

7.13 No-Fault Automobile Insurance

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

7.14 Services Separately Billed by Hospital Employees

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

7.15 Services Provided by a Family Member

We do not Cover services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your spouse.

7.16 Services With No Charge

We do not Cover services for which no charge is normally made.

7.17 Services not Listed

We do not Cover services that are not listed in this Contract as being Covered.

7.18 Vision Services

We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in Section VI of this Contract.

7.19 Workers' Compensation

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

7.20 War

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

SECTION VIII. CLAIM DETERMINATION

8.1 Claims

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

8.2 Notice of Claim

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of

service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website at http://newyork.healthrepublic.us. Completed claim forms should be sent to the address in Section II of this Contract or on Your ID card.

8.3 Timeframe for Filing Claims

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible.

8.4 Claims for Prohibited Referrals

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

8.5 Claim Determinations

Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to Section IX of this Contract.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see Section IX of this Contract.

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

8.6 Pre-service Claim Determinations

If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

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

8.7 Urgent Pre-service Reviews

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

8.8 Post-service Claim Determinations

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

SECTION IX. GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS

9.1 Grievances

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

9.1.1 Filing a Grievance

You can contact Us by phone at 888.990.5702 or in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written

acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when you received the decision you are asking Us to review to file the Grievance.

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

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

9.1.2 Grievance Determination

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

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided Within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for service.)	In writing, within 30 calendar days of receipt of Your Grievance.

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

Call the New York State Department of Financial Services at
1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

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

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

9.2 UTILIZATION REVIEW

9.2.1 Utilization Review

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

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

9.2.2 Preauthorization Reviews

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

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

9.2.3 Urgent Preauthorization Reviews

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

After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of the necessary information.

If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

9.2.4 Concurrent Reviews
Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of all necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business of Our receipt of the information or, if We do not receive the information, within 1 business day of the end of the 45-day time period.

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

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

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

9.2.7 Retrospective Review of Preauthorized Services
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

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

9.2.8 Reconsideration

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

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

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

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

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

9.2.10 Standard Appeal
If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

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

9.2.11 Expedited Appeals

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

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

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

I. YOUR RIGHT TO AN EXTERNAL APPEAL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. THE EXTERNAL APPEAL PROCESS

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

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

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

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

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

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

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

We will charge You a fee of (insert any amount up to $25) for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

VI. YOUR RESPONSIBILITIES

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

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

SECTION X. TERMINATION OF COVERAGE

Coverage under this Contract may be terminated as follows:

1. Coverage under this Contract shall automatically be terminated on the first of the following to apply:

a. Upon Your death, coverage under this Contract will terminate unless You have coverage for Dependents. If You have coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium has been paid.
b. For Spouses in cases of divorce, the date of the divorce.
c. For Children, until the end of the month in which the Child turns 26 years of age. For all other Dependents, the date in which the Dependent ceases to be eligible.

2. You may terminate coverage under this Contract at any time by giving Us at least 30 days prior written notice.

3. We may terminate coverage under this Contract on 30 days written notice as follows:
   a. For non-payment of Premiums. Premiums are to be paid by You to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
   If You fail to pay the required Premium within a 30 day grace period, coverage will terminate retroactively back to the last date Premiums were paid. You will be responsible to pay for any claims submitted during the grace period.
   b. If You have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on Your enrollment application or in order to obtain coverage for a service, coverage will terminate immediately upon a written notice to You from Us. However, if You make an intentional misrepresentation of material fact in writing on Your enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage and Your application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Contract.
   c. If You no longer live, reside, or work in Our Service Area.
   d. The date on which You cease to meet the eligibility requirements for coverage.
   e. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide You with at least 90 days prior written notice.
   f. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this state. We will provide written notice to You at least 180 days prior to when Your coverage will cease.

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

See Section XI of this Contract for Your right to conversion to an individual Contract.

SECTION XI. WHAT HAPPENS IF YOU LOSE COVERAGE

11.1 Extension of Benefits

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

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

11.1.1. When You May Continue Benefits

If You are totally disabled on the date Your coverage under this Contract terminates, We will continue to pay for Your care under this Contract during an uninterrupted period of total disability until the first of the following:

- The date You are no longer totally disabled.
- 12 months from the date this Contract terminated.

11.1.2. Limits on Extended Benefits

We will not pay extended benefits:

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

11.2 Conversion Right to New Contract After Termination

The Subscriber's Spouse and Children have the right to convert to a new Contract if their coverage under this Contract terminates under the circumstances described below.

A. **Termination of Your Marriage.** If a Spouse's coverage terminates under Section X of this Contract because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.
B. **Termination of Coverage of a Child.** If a Child's coverage terminates under Section X of this Contract because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.
C. **On the Death of the Subscriber.** If coverage terminates under Section X of this Contract because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

11.2.1 When to Apply for the New Contract

If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of Your coverage under this Contract. You must also pay the first Premium of the new Contract at the time You apply for coverage.

11.2.2 The New Contract

We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. You may choose among any of the four Policies offered by Us.

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

11.2.4 Temporary Suspension Rights for Members of the Armed Forces
If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

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

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned premiums will be refunded during the period of such suspension.

Upon completion of active duty:

Your coverage may be resumed as long as You make written application to Us and remit the premium within 60 days of the termination or active duty. The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XII. GENERAL PROVISIONS

1. **Agreements between Us and Participating Providers:** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Contract does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. **Assignment:** You cannot assign any benefits or monies due under this Contract to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Contract or your right to collect money from us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. **Changes in This Contract:** We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.

4. **Choice of Law:** This Contract shall be governed by the laws of the State of New York.

5. **Clerical Error:** Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. **Continuation of Benefit Limitations:** Some of the benefits under this Contract may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

7. **Entire Agreement:** This Contract, including any endorsements, riders and the attached applications, if any, constitutes the entire Contract.

8. **Furnishing Information and Audit:** All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

9. **Identification Cards:** Identification cards are issued by Us for identification only. Possession of any identification card confers no right to services or benefits under this Contract. To be entitled to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.

10. **Incontestability:** All statements contained in any such written instrument shall be deemed representations and not warranties.

    No statement by You in an application for coverage under this Contract shall void the Contract or be used in any legal proceeding unless the application is or an exact copy is attached to this Contract. After two years from the date of issue of this Contract no misstatements, except for

fraudulent misstatements made by the Subscriber in the application for coverage shall be used to void the Contract or deny a claim.

11. **Independent Contractors**: Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's facility.

12. **Material Accessibility:** We will give You identification cards, Certificates, riders, and other necessary materials.

13. **More Information about Your Health Plan:** You can request additional information about Your coverage under this Contract. Upon Your request, We will provide the following information.
    - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
    - The information that We provide the State regarding Our consumer complaints.
    - A copy of Our procedures for maintaining confidentiality of Member information.
    - A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Contract.
    - A written description of Our quality assurance program.
    - A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
    - Provider affiliations with Participating Hospitals.
    - A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.

14. **Notice:** Any notice that We give to You under this Contract will be mailed to Your address as it appears on our records. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: Health Republic Insurance of New York, 30 Broad Street, 34th Floor, New York NY 10004. You may also upload it via the secured member section of our website at http://newyork.healthrepublic.us.

15. **Premium Payment**: The initial premium is payable one month in advance by You to Us at Our office. The first month's premium is due and payable upon submission of the application. Coverage will begin on the effective date of the Contract as defined herein. Subsequent premiums are due and payable on the first of each month thereafter.

16. **Premium Refund:** We will give any refund of Premiums, if due, to You.

17. **Recovery of Overpayments:** On occasion a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment

recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

18. **Renewal Date:** The renewal date for the Contract is January 1 of each Year. This Contract will automatically renew each year on the renewal date unless otherwise terminated by Us as permitted by the Contract, or by You upon 30 days' prior written notice to You.

19. **Reinstatement After Default.** If You default in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers 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.

20. **Right to Develop Guidelines and Administrative Rules:** We may develop or adopt standards that describe in more detail when We will make or will not make payments under this Contract. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether surgery was Medically Necessary to treat Your illness or injury; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Contract.

21. **Right to Offset:** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

22. **Severability:** The unenforceability or invalidity of any provision of the Contract shall not affect the validity and enforceability of the remainder of the Contract.

23. **Significant Change in Circumstances**: If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

24. **Subrogation and Reimbursement:** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Contract. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

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

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

25. **Time to Sue:** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within 2 years from the date the claim was required to be filed.

26. **Translation Services:** Translation services are available under this Contract for non-English speaking Members. Please contact us at 888.990.5702 to access these services.

27. **Venue for Legal Action:** If a dispute arises under this Contract, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to these courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order You to defend any action We bring against You.

28. **Waiver:** The waiver by any party of any breach of any provision of the Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

29. **Who May Change This Contract:** The Contract may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer (CEO) or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

30. **Who Receives Payment under This Contract:** Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

31. **Workers' Compensation Not Affected:** The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

32. **Your Medical Records and Reports:** In order to provide Your coverage under this Contract, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Contract, You automatically give Us or our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:
    - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
    - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
    - Permit copying of Your medical records by Us.

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

HEALTH REPUBLIC
INSURANCE

This is Your

EXCLUSIVE PROVIDER ORGANIZATION CONTRACT

Issued by

Freelancers Health Service Corporation
DBA
Health Republic Insurance of New York
30 Broad Street 34th Floor~~112 West 24th Street, Suite 17058~~
New York, NY 10004~~120~~

This is Your individual direct payment Contract for exclusive provider organization coverage issued by Freelancers Health Service Corporation DBA Health Republic Insurance of New York. This Contract, together with the attached Schedule of Benefits, applications, and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten days from the date You receive this Contract. We will refund any Premium paid including any Contract fees or other charges.

This Contract offers You the option to receive Covered Services on two benefit levels:

In-Network Preferred Benefits. In-network preferred benefits are the highest level of coverage available. In-network preferred benefits apply when Your care is provided by Preferred Providers in Our MagnaCare[sm] Choice Network. You should always consider receiving health services first through the Preferred Providers in Our preferred MagnaCare[sm] Choice Network.

In-Network Benefits. In-network benefits are the intermediate level of coverage available. In-network benefits apply when Your care is provided by Participating Providers that are not Preferred Providers and are in Our MagnaCare[sm] Extra Network. You should always consider receiving health care services first through Preferred Providers and then from Non- Preferred Providers.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

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

Signed By: _____

Debra Friedman~~aniel T. McGowan~~
Chief Executive Officer

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SECTION I. DEFINITIONS

Defined terms will appear capitalized throughout the Contract.

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

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See Section IV of this Contract for a description of how the Allowed Amount is calculated.

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

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

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

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

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

Contract: This Contract issued by Freelancers Health Service Corporation DBA Health Republic Insurance of New York, including the Schedule of Benefits and any attached riders.

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

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

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

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

Dependents: The Subscriber's Spouse and Children.

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

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

- is appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

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

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

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

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

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

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

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

Health Care Professional: An appropriately licensed, registered, or certified Physician; osteopath; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist certified to

administer immunizing agents; or any other licensed, registered, or certified Health Care Professional under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Contract.

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

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

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

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (RN);
- if located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 U.S.C. § 1395x(k));
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

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

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

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

Medically Necessary: See Section II of this Contract for the definition.

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

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

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

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

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website ~~[www.newyorkcoop.org~~http://~~]~~newyork.healthrepublic.us/network or upon Your request to Us. The list will be revised from time to time by Us. You will pay higher Cost-Sharing to see a Participating Provider as compared to a Preferred Provider, but less than if You received Covered Services from a Non-Participating Provider.

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

Plan Year: A 12-month calendar year.

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

Preferred Provider: A Provider who has a contract with Us to provide services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.

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

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

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

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

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

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

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties for the MagnaCare[sm] Extra Network: Albany, Bronx, Brooklyn, Chautauqua, Columbia, Delaware, Dutchess, Erie, Essex, Greene,

Hamilton, Monroe, Nassau, New York, Niagara, Onandaga, Ontario, Orange, Orleans, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Staten Island, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester. Our Service Area consists of the following counties for the MagnaCare[sm] Choice Network: Bronx, Essex, Hamilton, Nassau, New York, and Westchester.

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

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

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse and a Domestic Partner.

Subscriber: The person to whom this Contract is issued.

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

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

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

Us, We, Our: Freelancers Health Service Corporation DBA Health Republic Insurance of New York and anyone to whom We legally delegate to perform, on Our behalf, under the Contract.

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

You, Your: The Member.

SECTION II. HOW YOUR COVERAGE WORKS

2.1 Your Coverage under this Contract

You have purchased a Freelancers Health Service Corporation DBA Health Republic Insurance of New York Contract from Us. We will provide the benefits described in this Contract to You and Your Covered Dependents. You should keep this Contract with Your other important papers so that it is available for Your future reference.

2.2 Covered Services

You will receive Covered Services under the terms and conditions of this Contract only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits in Section XIII of this Contract; and
- Received while Your Contract is in force.

2.3 Participating Providers

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request.
- Call Member Services.
- Visit our website ~~[www.newyorkcoop.org].~~ http://newyork.healthrepublic.us/network.

2.4 Preferred Providers

Some Participating Providers are also Preferred Providers. Certain services must be obtained from Preferred Providers. See the Schedule of Benefits in Section XIII of this Contract for coverage of Preferred Provider services.

2.5 The Role of Primary Care Physicians

This Contract does not have a gatekeeper, usually known as a Primary Care Physician (PCP). You do not need a written Referral from a PCP before receiving Specialist care from a Participating Provider. You may visit any Participating PCP who is available from the list of PCPs in the EPO MagnaCare[sm] Extra Network and MagnaCare[sm] Choice Network. For purposes of Cost-Sharing, if You seek services from a Primary Care Physician (or a Physician covering for a Primary Care Physician) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits in section XIII of this Contract.

However, You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits in Section XIII of this Contract for the services that require Preauthorization.

2.6 Services Subject To Preauthorization

Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network services listed in the Schedule of Benefits in Section XIII of this Contract.

2.7 Preauthorization/Notification Procedure

If You seek coverage for services that require Preauthorization or notification, You must call Us at the number indicated on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least two weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then during regular business hours prior to the admission.
- At least two weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in a free standing Ambulatory Surgical Center.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

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

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

2.8 Failure to Seek Preauthorization or Provide Notification

If You fail to seek Our Preauthorization or provide notification for benefits subject to this Section, We will pay an amount $500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary, even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

2.9 Medical Management

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

2.10 Care Must Be Medically Necessary

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

We may base Our decision on a review of: Your medical records; Our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data; professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or

treatment; the opinion of Health Care Professionals in the generally recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

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

See Section IX of this Contract for Your right to an internal appeal and external appeal of Our determination that a service is not Medically Necessary.

2.11 Important Telephone Numbers and Addresses

CLAIMS
*Submit claim forms to this address.
Health Republic Insurance of New York
P.O. Box 6329
Syracuse, NY 13217-6329

COMPLAINTS, GRIEVANCES, AND UTILIZATION REVIEW APPEALS
Health Republic Insurance of New York
2425 James Street
Syracuse, NY 13206
Phone: 888.990.5702
Fax: 315-433-5445

MEMBER SERVICES
* Member Services Representatives are available Monday – Friday 8:30 a.m. – 5:30 p.m. EST
Phone: 888.990.5702
Fax: 315-432-9442

PREAUTHORIZATION
Monday – Friday 8:00 a.m. – 6:00 p.m. EST
Phone: 888.990.5702
Fax: 315-433-5442

~~CLAIMS~~

~~*Submit claim forms to this address.~~
~~Health Republic Insurance of New York~~
~~P.O. Box 6329~~
~~Syracuse, NY 13217-6329~~

~~COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS~~
~~Health Republic Insurance of New York~~
~~2425 James Street~~
~~Syracuse, NY 13206~~
~~Phone: 888.990.5702~~
~~Fax: 315.432.9442 or 315.432.1689~~

~~MEDICAL EMERGENCIES AND URGENT CARE~~
~~Phone: 888.990.5702~~
~~Fax: 315.432.9442 or 315.432.1689~~
~~[Weekdays 8:00 a.m. – 5:00 p.m.]~~

~~MEMBER SERVICES~~
~~[Member Services Representatives are available Monday – Friday 8:00 a.m. – 5:00 p.m. EST]~~
~~Phone: 888.990.5702~~

~~PREAUTHORIZATION~~
~~[Monday – Friday 8:00 a.m. – 6:00 p.m. EST]~~
~~Phone: 888.990.5702~~
~~Fax: 315.463.1483~~
~~[website]~~

Comment [asp1]: What is it?

SECTION III. ACCESS TO CARE AND TRANSITIONAL CARE

3.1 Referral to a Non-Participating Provider

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

3.2 When Your Provider Leaves the Network

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

In order for You to continue to receive Covered services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to

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

3.3 New Members In a Course of Treatment

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

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

SECTION IV. COST-SHARING EXPENSES AND ALLOWED AMOUNT

For further details, refer to the Schedule of Benefits in Section XIII.

4.1 Deductible

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

4.2 Copayments

Except where stated otherwise, after You have satisfied the annual Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits in Section XIII of this Contract for Covered in-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

4.3 Coinsurance

Except where stated otherwise, after You have satisfied the annual Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network benefit as shown in the Schedule of Benefits in Section XIII of this Contract.

4.4 Primary Care; Office Visit Allowance

We Cover Services provided in an office setting for diagnostic evaluation and treatment in full for each Member until the allowance described in the Schedule of Benefits in Section XIII of this Contract is exhausted for a Plan Year. Once the allowance is exhausted, the Cost-Sharing in the Schedule of Benefits will apply. Services included in the allowance are those provided by Your Primary Care Physician or Your Primary Care Physician whose specialty is exclusively internal medicine, family practice, general practice, OB/GYN or pediatrics.

Preventive services required to be covered at no Cost-Sharing do not count towards the allowance.

4.5 Out-of-Pocket Limit

When You have met Your Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits in Section XIII of this Contract, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If other than Individual coverage applies, when members of the same family covered under this Contract have collectively met the family Out-of-Pocket Limit in payment of Deductibles, Copayments and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year.

4.6 Allowed Amount

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

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

See Section IV of the Contract for the Allowed Amount for an Emergency Condition.

SECTION V. WHO IS COVERED

5.1 Who is Covered Under this Contract

You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live, work, or reside in Our Service Area to be covered under this Contract. If You are eligible for Medicare, You are not eligible to purchase this Contract. If You selected one of the following types of coverage, members of Your family may also be covered.

5.2 Types of Coverage

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

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

5.3 Children Covered Under This Contract

If You selected Parent and Child/Children or Family coverage, "Children" covered under this Contract include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap, and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this Section.

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

5.4 Open Enrollment

You can enroll under this Contract during an initial open enrollment period that runs from October 1, 2013 through March 31, 2014. If We receive Your selection between the first and fifteenth day of October, November, or December of 2013, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received by Us between the sixteenth and last day of the month of October, November or December of 2013, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then. If Your selection is received by Us between the first and fifteenth day of the month of January, February, or March of 2014, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received by Us between the sixteenth and last day of the month of December 2013, January, February, or March of 2014,

Your coverage will begin on the first day of the second month, as long as Your applicable premium payment is received by then.

You can enroll under this Contract during an annual open enrollment period that runs from October 15 through December 7. If We receive Your selection between these dates, Your coverage will begin on January 1 of the following year, as long as the applicable premium payment is received by then.

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

5.5 Special Enrollment Periods

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days of the occurrence of one of the following events:

- You or Your Spouse or Child loses minimum essential coverage.
- Your enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan or the Exchange.
- You adequately demonstrate to Us that another health plan in which You were enrolled substantially violated a material provision of its contract.
- You move and become eligible for new health plans;
- You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.
- You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions; or
- You, Your Spouse or Child exhausted Your COBRA or continuation coverage.

We must receive notice and We must receive any premium payment within 60 days of one of these events.

If You enroll because You lost minimum essential coverage or because You got married, Your coverage will begin on the first day of the month following Your loss of coverage or marriage.

If You have a newborn or adopted newborn Child and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have Individual or Individual and Spouse coverage You must also pay any additional premium for Parent and Child/Children or Family coverage within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise coverage begins on the date on which We receive notice and the premium payment.

In all other cases, the effective date of Your coverage will depend on when We receive Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable premium payment is received by then. If

Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable premium payment is received by then.

5.6 Domestic Partner Coverage

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

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
   a. The affidavit must be notarized and must contain the following:
      - The partners are both eighteen years of age or older and are mentally competent to consent to contract;
      - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
      - The partners have been living together on a continuous basis prior to the date of the application;
      - Neither individual has been registered as a member of another domestic partnership within the last six months; and
   b. Proof of cohabitation (e.g., a driver's license, tax return, or other sufficient proof); and
   c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
      - A joint bank account
      - A joint credit card or charge card
      - Joint obligation on a loan
      - Status as an authorized signatory on the partner's bank account, credit card or charge card
      - Joint ownership of holdings or investments
      - Joint ownership of residence
      - Joint ownership of real estate other than residence
      - Listing of both partners as tenants on the lease of the shared residence
      - Shared rental payments of residence (need not be shared 50/50)
      - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
      - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
      - Shared household budget for purposes of receiving government benefits
      - Status of one as representative payee for the other's government benefits
      - Joint ownership of major items of personal property (e.g., appliances, furniture)
      - Joint ownership of a motor vehicle
      - Joint responsibility for child care (e.g., school documents, guardianship)
      - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
      - Execution of wills naming each other as executor and/or beneficiary
      - Designation as beneficiary under the other's life insurance policy
      - Designation as beneficiary under the other's retirement benefits account

- Mutual grant of durable power of attorney
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
- Affidavit by creditor or other individual able to testify to partners' financial interdependence
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI. COVERED SERVICES

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

6.1 Preventive Care

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at 888.990.5702 or visit Our website at http://newyork.healthrepublic.us ~~[www.newyorkcoop.org]~~ for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

6.1.1 Well-Baby and Well-Child Care

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

6.1.2 Adult Annual Physical Examinations

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

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening, and diabetes screening. A complete list of the Covered preventive services is available on Our website at http://newyork.healthrepublic.us, ~~[www.newyorkcoop.org],~~ or will be mailed to You upon request.

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

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

6.1.3 Adult Immunizations

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

6.1.4 Well-Woman Examinations

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

6.1.5 Mammograms

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

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

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

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles or Coinsurance.

6.1.6 Family Planning and Reproductive Health Services

We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug benefit in Section VI of the Contract, counseling on use of contraceptives, related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies.

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

6.1.7 Bone Mineral Density Measurements or Testing

We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to Section VI of the Contract. Bone mineral density measurements or tests, drugs, or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in

accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

6.1.8 Screening for Prostate Cancer

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

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

6.2 PRE-HOSPITAL EMERGENCY MEDICAL SERVICES AND AMBULANCE SERVICES

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

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

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

- Placing the health of the person afflicted with such condition or, with
- respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or

- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable Copayment, Coinsurance, or Deductible.

Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

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

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

See the Schedule of Benefits in Section XIII of this Contract for any Preauthorization requirements for non-emergency transportation.

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

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

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

6.3 EMERGENCY SERVICES

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

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

We define an **Emergency Condition** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or

- Serious disfigurement of such person.

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

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

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

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

- A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and
- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

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

6.3.1 Hospital Emergency Department Visits

In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition, as defined above, are Covered in an emergency department**. If You are uncertain whether this is the most appropriate place to receive care You can call Us before You seek treatment. Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

Follow-up care or routine care provided in a Hospital emergency department is not Covered. You should contact Us to make sure You receive the appropriate follow-up care.

6.3.2 Emergency Hospital Admissions

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

We Cover inpatient Hospital services at a Non-Participating Hospital at the In-Network Cost-Sharing for as long as Your medical condition prevents Your transfer to a Participating Hospital, unless We authorize continued treatment at the Non-Participating Hospital. If Your medical condition permits Your transfer to a Participating Hospital We will notify You and arrange the transfer. Any inpatient Hospital services received from a Non-Participating Hospital after we have notified You and arranged for a transfer to a Participating Hospital will not be Covered. See Section IX of the Contract for Your Appeal rights.

6.3.3 Payments Relating to Emergency Services Rendered

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

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

6.4 URGENT CARE

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

A. In-Network

You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center.

B. Out-of-Network

We do not cover Urgent Care from Non-Participating Urgent Care Centers or Physicians in Our Service Area.

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

6.5 OUTPATIENT AND PROFESSIONAL SERVICES

(For other than Mental Health and Substance Use)

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

6.5.1 Acupuncture

We cover acupuncture services.

6.5.2 Advanced Imaging Services

We Cover PET scans, MRI, nuclear medicine, and CAT scans.

6.5.3 Allergy Testing and Treatment

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

6.5.4 Ambulatory Surgery Center

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

6.5.5 Chemotherapy

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

6.5.6 Chiropractic Services

We Cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of the vertebral column. This includes assessment, manipulation, and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Contract.

6.5.7 Dialysis

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

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

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

6.5.8 Habilitation Services

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

6.5.9 Home Health Care

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

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

6.5.10 Interruption of Pregnancy

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

6.5.11 Infertility Treatment

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

- Basic Infertility Services. Basic Infertility Services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultra sound, hysterosalpingogram, sono-hystogram, testis biopsy, blood tests, and medically appropriate treatment of ovulatory dysfunction. Additional tests may be Covered if the tests are determined to be Medically Necessary.
- Comprehensive Infertility Services. If the Basic Services do not result in increased fertility, We Cover Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.
- Exclusions and Limitations
    a. In vitro, GIFT, and ZIFT procedures.
    b. Cost for an ovum donor or donor sperm.
    c. Sperm storage costs.
    d. Cryopreservation and storage of embryos.
    e. Ovulation predictor kits.
    f. Reversal of tubal ligations. Reversal of vasectomies.
    g. All costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers).
    h. Sex change procedures.
    i. Cloning.
    j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.

k. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

6.5.12 Infusion Therapy

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

6.5.13 Laboratory Procedures, Diagnostic Testing, and Radiology Services

We Cover x-ray, laboratory procedures, and diagnostic testing, services, and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

6.5.14 Maternity and Newborn Care

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

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

6.5.15 Medications for Use in the Office:

We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes.

6.5.16 Office Visits

We Cover office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls.

6.5.17 Outpatient Hospital Services

We Cover Hospital services and supplies as described in the Inpatient Hospital Section that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy, and cardiac rehabilitation. **Please remember**, unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

6.5.18 Preadmission Testing

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

6.5.19 Rehabilitation Services

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

We Cover speech and physical therapy only when:

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

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

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

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

6.5.20 Second Opinions

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

6.5.21 Surgical Services

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for

anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

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

- Through the Same Incision. If Covered multiple surgical procedures are through the same incision, We will pay for the procedure with the highest Allowed Amount.

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

6.5.22 Oral Surgery

We Cover the following limited dental and oral surgical procedures:

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

6.5.23 Reconstructive Breast Surgery

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

6.5.24 Other Reconstructive and Corrective Surgery

We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when:

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

6.5.25 Transplants

We Cover only those transplants determined to be nonexperimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich Syndrome.

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

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

We do not Cover travel expenses, lodging, meals, or other accommodations for donors or guests. We do not Cover donor fees in connection with organ transplant surgery. We do not Cover routine harvesting and storage of stem cells from newborn cord blood.

6.6 ADDITIONAL BENEFITS, EQUIPMENT, AND DEVICES

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

6.6.1 Autism Spectrum Disorder

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

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

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

- **Behavioral Health Treatment:** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

  Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.
- **Psychiatric and Psychological Care**: We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.
- **Therapeutic Care:** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.
- **Pharmacy Care**: We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Contract.

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

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

Nothing in this Contract shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

6.6.2 Diabetic Equipment, Supplies, and Self-Management Education

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

6.6.3 Supplies

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

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

6.6.4 Self-Management Education

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

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

6.6.5 Limitations

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

6.6.6 Durable Medical Equipment and Braces

We Cover the rental or purchase of durable medical equipment and braces.

6.6.7 Durable Medical Equipment

Durable Medical Equipment is equipment which is:

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

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

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

6.6.8 Braces

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

6.6.9 Hearing Aids

We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

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

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

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

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

6.6.10 Hospice

Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

6.6.11 Medical Supplies

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

6.7 PROSTHETICS

6.7.1 External Prosthetic Devices

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this Section of the Contract and are only covered under the pediatric vision benefit in Section VI in this Contract. We do not Cover orthotics.

For adults, We Cover the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

Coverage is for standard equipment only. We do not otherwise Cover the cost of repairs or replacement.

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

6.7.2 Internal Prosthetic Devices

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.

6.8 INPATIENT SERVICES

(For other than Mental Health and Substance Use)

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

6.8.1 Hospital Services

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

- Semiprivate room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and cystoscopic rooms and equipment;
- The use of intensive care, special care, or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations, and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy, and cardiac rehabilitation;
- Short-term physical, speech, and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

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

6.8.2 Observation Services

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

6.8.3 Inpatient Medical Services

We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Contract.

6.8.4 Inpatient Stay for Maternity Care

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

6.8.5 Inpatient Stay for Mastectomy Care

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

6.8.6 Autologous Blood Banking Services

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

6.8.7 Rehabilitation Services

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

We Cover speech and physical therapy only when:

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

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

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

6.8.8 Skilled Nursing Facility

We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent, or domiciliary care is not Covered (see the “Exclusions and Limitations” Section of this Contract). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to ~~200~~ 365 days, per Plan Year, for non-custodial care.

6.8.9 End of Life Care

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Contract until the External Appeal Agent renders a decision in Our favor.

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

1. We will reimburse a rate that has been negotiated between Us and the Provider.

2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare acute care service rates.

3. Or if it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare rates.

6.8.10 Limitations/Terms of Coverage

1. When You are receiving inpatient care in a Hospital or other Facility as described above, We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.

2. We do not Cover radio, telephone, and television expenses, or beauty or barber services.

3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

6.9 MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES

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

6.9.1 MENTAL HEALTH CARE SERVICES

A. Inpatient Services

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

B. Outpatient Services

We Cover outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of

mental, nervous, and emotional disorders. Such Coverage is limited to Facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a Facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker ~~who meets the requirements of NY Ins. Law §§ 3221(l)(4)(D), 4303(h)(1)~~; or a professional corporation or a university faculty practice corporation thereof.

C. Limitations/Terms of Coverage

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

6.9.2 SUBSTANCE USE SERVICES

A. Inpatient Services

We Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes Coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs.

B. Outpatient Services

We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such Coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV, and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

We also Cover up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Contract that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

6.10 PRESCRIPTION DRUG COVERAGE

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

6.10.1 Covered Outpatient Prescription Drugs

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

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

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.
- Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the Infertility Section of this Contract.
- Off-Label Cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at http://newyork.healthrepublic.us/formulary~~[www.newyorkcoop.org].~~ You may also inquire if a specific drug is Covered under this Contract by contacting us at the number on Your ID card.

6.10.2 Refills

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits in Section XIII of this Contract.

6.10.3 Benefit and Payment Information

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

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

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

   You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

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

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

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at 888.990.5702 or visit our website at http://newyork.healthrepublic.us ~~[www.newyorkcoop.org]~~ to request approval.

C. **Non-Participating Pharmacies:** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

D. **Designated Pharmacies:** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

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

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

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

- Age related macular edema
- Anemia, neutropenia, thrombocytopenia
- Contraceptives
- Crohn's Disease
- Cystic Fibrosis
- Cytomegalovirus
- Endocrine disorders/Neurologic disorders such as infantile spasms
- Enzyme Deficiencies/Liposomal Storage Disorders
- Gaucher's Disease
- Growth Hormone
- Hemophilia
- Hepatitis B, Hepatitis C
- Hereditary Angioedema
- HIV/AIDS
- Immune Deficiency
- Immune Modulator
- Infertility
- Iron Overload
- Iron Toxicity
- Multiple Sclerosis
- Oral Oncology
- Osteoarthritis
- Osteoporosis
- Parkinson's Disease
- Pulmonary Arterial Hypertension
- Respiratory Condition
- Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis,Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
- Transplant
- RSV Prevention

E. **Mail Order:** Certain Prescription Drugs may be ordered through Our mail order supplier. We will only cover maintenance drugs through a mail order pharmacy. Other drugs may also be purchased at a mail order pharmacy. You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

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

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

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

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at http://newyork.healthrepublic.us/formulary ~~[www.newyorkcoop.org]~~ or by calling the Customer Service number on Your ID card. The maintenance drug list is updated periodically. Visit our website or call the Customer Service number on Your ID card to find out if a particular drug is on the maintenance list.

F. **Tier Status:** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at http://newyork.healthrepublic.us~~[www.newyorkcoop.org]~~ or by calling the Customer Service number on Your ID card.

G. **When a Brand-Name Drug Becomes Available As a Generic:** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in Section IX of the Contract.

H. **Supply Limits:** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply. However, for maintenance drugs we will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for one Cost-Sharing amount; up to three Cost-Sharing amounts for a 90-day supply at a retail pharmacy.

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

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for

dispensing by accessing Our website at http://newyork.healthrepublic.us ~~[www.newyorkcoop.org]~~ or by calling Customer Service at the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to Section IX of the Contract.

I. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits in Section XIII of this Contract or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under Section VI of this Contract.

6.10.4. Medical Management

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

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

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

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

C. **Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website ~~at [www.newyorkcoop.org]~~at http://newyork.healthrepublic.us or call the Customer Service at the phone number on Your ID Card.

6.10.5 Limitations/Terms of Coverage

A. We reserve the right to limit quantities, day supply, early Refill access, and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

B. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You don't make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

C. Compounded Prescription Drugs will be Covered only when they contain at least one ingredient that is a Covered legend Prescription Drug, are Medically Necessary, and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs require You to obtain Preauthorization.

D. Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

J. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies are not Covered under this Section but are Covered under other Sections of this Contract.

K. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under Section VI of this Contract.

L. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs or as otherwise provided in this Contract.

M. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

N. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

O. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency, or home care services agency, or other institution, does not include services for drugs.

P. Your benefit for insulin, diabetic Prescription Drugs, supplies, and equipment is not provided under this Section of the Contract and is Covered under Section VI of the Contract. Your benefit for insulin and diabetic Prescription Drugs, supplies and equipment will be provided under this Section of the Contract if the Cost-Sharing is more favorable to You under this Section of the Contract than the Cost-Sharing under Section XIII of the Contract.

Q. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in Section IX of this

Contract.

R. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

S. We do not Cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products except as described under the Covered Outpatient Prescription Drug Section.

6.10.6. General Conditions

A. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

B. **Drug Utilization, Cost Management, and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may, from time-to-time, also enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors, or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities, and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

6.10.7 DEFINITIONS

Terms used in this Section are defined as follows. (Other defined terms can be found in the Definitions Section of this Contract).

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

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

Formulary: The list that identifies those Prescription Drugs for which Coverage may be available under this Contract. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug

has been assigned by visiting Our website at http://newyork.healthrepublic.us/formulary ~~[www.newyorkcoop.org]~~ or by calling the Customer Service number on Your ID card.

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

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

Participating Pharmacy: A pharmacy that has:

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

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

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

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

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

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

6.11 WELLNESS BENEFITS

Exercise Facility Reimbursement
We will partially reimburse the Subscriber and the Subscriber's Covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities that We have an agreement with and which maintain equipment and programs that promote cardiovascular wellness.

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

In order to be eligible for reimbursement, You must:

- be an active member of the exercise facility, and
- complete 50 visits in a six-month period.

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

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

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of $200 for the Subscriber and $100 for the Subscriber's Spouse or the actual cost of the membership per six-month period.

6.12 PEDIATRIC VISION

Pediatric Vision Care

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

6.12.1 Pediatric Vision Care

We Cover emergency, preventive, and routine vision care for Children up to age 19.

6.12.2 Vision Examinations

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

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

6.12.3 Prescribed Lenses and Frames

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

SECTION VII. EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Contract for the following:

7.1 Aviation

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

7.2 Convalescent and Custodial Care

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

7.3 Cosmetic Services

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

7.4 Coverage Outside of the United States, Canada or Mexico

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

7.5 Dental Services

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

7.6 Experimental or Investigational Treatment

We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Contract for non-investigational treatments. See Section IX of this Contract for a further explanation of Your Appeal rights.

7.7 Felony Participation

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

7.8 Foot Care
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, except as specifically listed in this Contract. For foot care related to diabetes, see Section VI of this Contract.

7.9 Government Facility
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state, or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

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

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

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

7.13 No-Fault Automobile Insurance
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

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

7.15 Services Provided by a Family Member
We do not Cover services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your spouse.

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

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

7.18 Vision Services
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in Section VI of this Contract.

7.19 Workers' Compensation

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

7.20 War

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

SECTION VIII. CLAIM DETERMINATION

8.1 Claims

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

8.2 Notice of Claim

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website at http://newyork.healthrepublic.us. ~~[www.newyorkcoop.org].~~ Completed claim forms should be sent to the address in Section II of this Contract or on Your ID card.

8.3 Timeframe for Filing Claims

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 day period, You must submit it as soon as reasonably possible.

8.4 Claims for Prohibited Referrals

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

8.5 Claim Determinations

Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to Section IX of this Contract.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see Section IX of this Contract.

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

8.6 Pre-Service Claim Determinations

If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our

receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

8.7 Urgent Pre-Service Reviews

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

8.8 Post-Service Claim Determinations

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

SECTION IX. GRIEVANCE, UTILIZATION REVIEW, AND EXTERNAL APPEALS

9.1 GRIEVANCES

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

9.1.1 Filing a Grievance

You can contact Us by phone at 888.990.5702 or in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when you received the decision you are asking Us to review to file the Grievance.

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

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

9.1.2 Grievance Determination

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

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided Within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for service.)	In writing, within 30 calendar days of receipt of Your Grievance.

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

Call the New York State Department of Financial Services at
1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

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

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

9.2 UTILIZATION REVIEW

9.2.1 Utilization Review

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

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

9.2.2 Preauthorization Reviews

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

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

9.2.3 Urgent Preauthorization Reviews

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

After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

9.2.4 Concurrent Reviews

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

9.2.5 Urgent Concurrent Reviews

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

9.2.6 Retrospective Reviews

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

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

9.2.7 Retrospective Review of Preauthorized Services

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

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

9.2.8 Reconsideration

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

9.2.9 Utilization Review Internal Appeals

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

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

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

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

9.2.10 Standard Appeal

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate, Your Provider, within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

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

9.2.11 Expedited Appeals

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

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

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

I. YOUR RIGHT TO AN EXTERNAL APPEAL

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

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

- The service, procedure, or treatment must otherwise be a Covered Service under the Contract; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or

- You file an external appeal at the same time as You apply for an expedited internal Appeal; or
- We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

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

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

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

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

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

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

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

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

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

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

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

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

V. THE EXTERNAL APPEAL PROCESS

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

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

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

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

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

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

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

We will charge You a fee of to $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

VI. YOUR RESPONSIBILITIES

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

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

SECTION X. TERMINATION OF COVERAGE

Coverage under this Contract may be terminated as follows:

1. Coverage under this Contract shall automatically be terminated on the first of the following to apply:
    a. Upon Your death, coverage under this Contract will terminate unless You have coverage for Dependents. If You have coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium has been paid.
    b. For Spouses in cases of divorce, the date of the divorce.
    c. For Children, until the end of the month in which the Child turns 26 years of age. For all other Dependents, the date in which the Dependent ceases to be eligible.

2. You may terminate coverage under this Contract at any time by giving Us at least 30 days' prior written notice.

3. We may terminate coverage under this Contract on 30 days' written notice as follows:
    a. For non-payment of Premiums. Premiums are to be paid by You to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
    If You fail to pay the required Premium within a 30 day grace period, coverage will terminate retroactively back to the last date Premiums were paid. You will be responsible to pay for any claims submitted during the grace period.
    b. If You have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on Your enrollment application or in order to obtain coverage for a service, coverage will terminate immediately upon a written notice to You from Us. However, if You make an intentional misrepresentation of material fact in writing on Your enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage and Your application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Contract.
    c. If You no longer live, reside, or work in Our Service Area.
    d. The date on You cease to meet the eligibility requirements for coverage.
    e. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide You with at least 90 days prior written notice.
    f. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this state. We will provide written notice to You at least 180 days prior to when Your coverage will cease.

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

See Section XI of this Contract for Your right to conversion to an individual Contract.

SECTION XI. WHAT HAPPENS IF YOU LOSE COVERAGE

11.1 EXTENSION OF BENEFITS

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

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

11.1.1 When You May Continue Benefits

If You are totally disabled on the date Your coverage under this Contract terminates, We will continue to pay for Your care under this Contract during an uninterrupted period of total disability until the first of the following:

- The date You are no longer totally disabled.
- 12 months from the date this Contract terminated.

11.1.2 Limits on Extended Benefits

We will not pay extended benefits:

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

11.2 CONVERSION RIGHT TO NEW CONTRACT AFTER TERMINATION

The Subscriber's Spouse and Children have the right to convert to a new Contract if their coverage under this Contract terminates under the circumstances described below.

A. **Termination of Your Marriage.** If a Spouse's coverage terminates under Section X of this Contract because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.
B. **Termination of Coverage of a Child.** If a Child's coverage terminates under Section X of this Contract because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.
C. **On the Death of the Subscriber.** If coverage terminates under Section X of this Contract because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

11.2.1 When to Apply for the New Contract

If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of Your coverage under this Contract. You must also pay the first Premium of the new Contract at the time You apply for coverage.

11.2.2 The New Contract

We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold, or platinum) that covers all benefits required by state and federal law. You may choose among any of the four Policies offered by Us.

11.2.3 When Conversion is Not Available

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

11.2.4 Temporary Suspension Rights for Members of the Armed Forces

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

A. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and

B. You serve no more than five years of active duty.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned premiums will be refunded during the period of such suspension.

Upon completion of active duty:

Your coverage may be resumed as long as You make written application to Us and remit the premium within 60 days of the termination or active duty. The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XII. GENERAL PROVISIONS

1. **Agreements between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Contract does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. **Assignment.** You cannot assign any benefits or monies due under this Contract to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Contract or your right to collect money from us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. **Changes in This Contract.** We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.

4. **Choice of Law.** This Contract shall be governed by the laws of the State of New York.

5. **Clerical Error.** Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. **Continuation of Benefit Limitations.** Some of the benefits under this Contract may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

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

8. **Furnishing Information and Audit.** All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

9. **Identification Cards.** Identification cards are issued by Us for identification only. Possession of any identification card confers no right to services or benefits under this Contract. To be entitled to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.

10. **Incontestability.** All statements contained in any such written instrument shall be deemed

representations and not warranties.

No statement by You in an application for coverage under this Contract shall void the Contract or be used in any legal proceeding unless the application is or an exact copy is attached to this Contract. After two years from the date of issue of this Contract no misstatements, except for fraudulent misstatements made by the Subscriber in the application for coverage shall be used to void the Contract or deny a claim.

11. **Independent Contractors**. Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse, or Children while receiving care from any Participating Provider or in any Participating Provider's facility.

12. **Material Accessibility.** We will give You identification cards, Certificates, riders, and other necessary materials.

13. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Contract. Upon Your request, We will provide the following information.
    - A list of the names, business addresses, and official positions of Our board of directors, officers, and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
    - The information that We provide the State regarding Our consumer complaints.
    - A copy of Our procedures for maintaining confidentiality of Member information.
    - A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Contract.
    - A written description of Our quality assurance program.
    - A copy of Our medical Contract regarding an experimental or investigational drug, medical device, or treatment in clinical trials.
    - Provider affiliations with Participating Hospitals.
    - A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment, or utilization review guidelines.

14. **Notice.** Any notice that We give to You under this Contract will be mailed to Your address as it appears on our records. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: Health Republic Insurance of New York, 30 Broad Street, 34th Floor, New York NY 10004. You may also upload it via the secured member section of our website at http://newyork.healthrepublic.us.~~112 West 34th Street, Suite 17058, New York, New York 10120.~~

15. **Premium Payment**: The initial premium is payable one month in advance by You to Us at Our office. The first month's premium is due and payable upon submission of the application. Coverage will begin on the effective date of the Contract as defined herein. Subsequent premiums are due and payable on the first of each month thereafter.

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

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

18. **Renewal Date.** The renewal date for the Contract is January 1 of each Year. This Contract will automatically renew each year on the renewal date unless otherwise terminated by Us as permitted by the Contract, or by You upon 30 days' prior written notice to You.

19. **Reinstatement After Default.** If You default in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers 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

20. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will make or will not make payments under this Contract. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether surgery was Medically Necessary to treat Your illness or injury; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Contract.

21. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

22. **Severability.** The unenforceability or invalidity of any provision of the Contract shall not affect the validity and enforceability of the remainder of the Contract.

23. **Significant Change in Circumstances**. If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

24. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness, or other condition and We have provided benefits related to that injury, illness, or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Contract. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

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

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

25. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within 2 years from the date the claim was required to be filed.

26. **Translation Services.** Translation services are available under this Contract for non-English speaking Members. Please contact us at 888.990.5702 to access these services.

27. **Venue for Legal Action.** If a dispute arises under this Contract, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to these courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order You to defend any action We bring against You.

28. **Waiver.** The waiver by any party of any breach of any provision of the Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

29. **Who May Change This Contract.** The Contract may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer (CEO) or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or

person designated by the CEO.

30. **Who Receives Payment under This Contract.** Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

31. **Workers' Compensation Not Affected.** The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

32. **Your Medical Records and Reports.** In order to provide Your coverage under this Contract, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Contract, You automatically give Us or our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:
    - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
    - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
    - Permit copying of Your medical records by Us.

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

HEALTH REPUBLIC
INSURANCE

This is Your

EXCLUSIVE PROVIDER ORGANIZATION CONTRACT

Issued by

Freelancers Health Service Corporation
DBA
Health Republic Insurance of New York
30 Broad Street 34th Floor~~[112 West 34th Street, Suite 17058~~
New York, New York 10004~~120]~~

This is Your individual direct payment Contract for exclusive provider organization coverage issued by Freelancers Health Service Corporation DBA Health Republic Insurance of New York. This Contract, together with the attached Schedule of Benefits, applications, and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid, including any Contract fees or other charges.

In-Network Benefits. This Contract only covers n-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in our MagnaCare[sm] Extra Network. Except for care for an Emergency Condition described in Section VI, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

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

Signed By: _____
~~Daniel T. McGowan~~Debra Friedman
Chief Executive Officer

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SECTION I. DEFINITIONS

Defined terms will appear capitalized throughout the Contract.

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

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See Section IV of this Contract for a description of how the Allowed Amount is calculated.

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

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

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

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

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

Contract: This Contract issued by Freelancers Health Service Corporation DBA Health Republic Insurance of New York, including the Schedule of Benefits and any attached riders.

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

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

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

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

Dependents: The Subscriber's Spouse and Children.

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

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

- appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

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

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

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

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

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

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

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

Health Care Professional: An appropriately licensed, registered or certified Physician; osteopath; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist certified to

administer immunizing agents; or any other licensed, registered or certified Health Care Professional under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized, who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Contract.

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

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

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

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- if located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 U.S.C. § 1395x(k));
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

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

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

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

Medically Necessary: See Section II of this Contract for the definition.

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

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

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

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

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at http://newyork.healthrepublic.us/network~~[www.newyorkcoop.org]~~ or upon Your request to Us. The list will be revised from time to time by Us.

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

Plan Year: A 12-month calendar year.

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

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

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

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

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

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

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

Service Area: The geographical area designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties: Albany, Bronx, Brooklyn, Chautauqua, Columbia, Delaware, Dutchess, Erie, Essex, Greene, Hamilton, Monroe, Nassau, New York, Niagara, Onandaga, Ontario, Orange, Orleans, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Staten Island, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint

Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare law; or as otherwise determined by Us to meet the standards of any of these authorities.

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

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

Subscriber: The person to whom this Contract is issued.

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

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

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

Us, We, Our: Freelancers Health Service Corporation DBA Health Republic Insurance of New York and anyone to whom We legally delegate to perform, on Our behalf, under the Contract.

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

You, Your: The Member.

SECTION II. HOW YOUR COVERAGE WORKS

2.1 Your Coverage under this Contract

You have purchased a Freelancers Health Service Corporation DBA Health Republic Insurance of New York Contract from Us. We will provide the benefits described in this Contract to You and Your Covered Dependents. You should keep this Contract with Your other important papers so that it is available for Your future reference.

2.2 Covered Services

You will receive Covered Services under the terms and conditions of this Contract only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits in Section XIII of this Contract; and
- Received while Your Contract is in force.

2.3 Participating Providers

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request.
- Call Member Services.
- Visit our website ~~at [~~at http://newyork.healthrepublic.us/network. ~~www.newyorkcoop.org].~~

2.4 The Role of Primary Care Physicians

This Contract does not have a gatekeeper, usually known as a Primary Care Physician (PCP). You do not need a written Referral from a PCP before receiving Specialist care from a Participating Provider. You mayvisit aParticipating PCP who is available from the list of PCPs in the EPO MagnaCare[sm] Extra Network. For purposes of Cost-Sharing, if You seek services from a Primary Care Physician (or a Physician covering for a Primary Care Physician) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits in section XIII of this Contract.

However, You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits in Section XIII of this Contract for the services that require Preauthorization.

2.5 Services Subject To Preauthorization

Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network services listed in the Schedule of Benefits in Section XIII of this Contract.

2.6 Preauthorization/Notification Procedure

If You seek coverage for services that require Preauthorization or notification, You must call Us at the number indicated on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least two weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then during regular business hours prior to the admission.
- At least two weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in a free standing Ambulatory Surgical Center.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

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

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

2.7 Failure to Seek Preauthorization or Provide Notification
If You fail to seek Our Preauthorization or provide notification for benefits subject to this Section, We will pay an amount $500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

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

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

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

Services will be deemed Medically Necessary only if:

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

See Section IX of this Contract for Your right to an internal appeal and external appeal of Our determination that a service is not Medically Necessary.

2.10 Important Telephone Numbers and Addresses

CLAIMS
*Submit claim forms to this address.
Health Republic Insurance of New York
P.O. Box 6329
Syracuse, NY 13217-6329

COMPLAINTS, GRIEVANCES, AND UTILIZATION REVIEW APPEALS
Health Republic Insurance of New York
2425 James Street
Syracuse, NY 13206
Phone: 888.990.5702
Fax: 315-433-5445

MEMBER SERVICES
* Member Services Representatives are available Monday – Friday 8:30 a.m. – 5:30 p.m. EST
Phone: 888.990.5702
Fax: 315-432-9442

PREAUTHORIZATION
Monday – Friday 8:00 a.m. – 6:00 p.m. EST
Phone: 888.990.5702
Fax: 315-433-5442

OUR WEBSITE
http://newyork.healthrepublic.us

~~CLAIMS~~
~~*Submit claim forms to this address.~~
~~Health Republic Insurance of New York~~
~~[P.O. Box 6329~~

~~Syracuse, NY 13217-6329]~~

~~COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS~~
~~Health Republic Insurance of New York~~
~~[2425 James Street~~
~~Syracuse, NY 13206]~~
~~Phone: [888-990-5702]~~
~~Fax: [315.432.9442 or 315.432.1689]~~

~~MEDICAL EMERGENCIES AND URGENT CARE~~
~~Phone: [888-990-5702]~~
~~Fax: [315. 432.9442 or 315.432.1689]~~
~~Weekdays [8:00 a.m. – 5:00 p.m.]~~

~~MEMBER SERVICES~~
~~* Member Services Representatives are available Monday – Friday [8:00 a.m. – 5:00 p.m. EST]~~
~~Phone: [888-990-5702]~~

~~PREAUTHORIZATION~~
~~Monday – Friday [8:00 a.m. – 6:00 p.m. EST]~~
~~Phone: [1.800.766.2648 or 888-990-5702]~~
~~Fax: [315.463.1483]~~

SECTION III. ACCESS TO CARE AND TRANSITIONAL CARE

3.1 Referral to a Non-Participating Provider

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

3.2 When Your Provider Leaves the Network

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

In order for You to continue to receive Covered services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

3.3 New Members In a Course of Treatment

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

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

SECTION IV. COST-SHARING EXPENSES AND ALLOWED AMOUNT

4.1 Deductible

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

4.2 Copayments

Except where stated otherwise, after You have satisfied the annual Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits in Section XIII of this Contract for Covered in-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

4.3 Coinsurance

Except where stated otherwise, after You have satisfied the annual Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of

the Allowed Amount as Your in-network benefit as shown in the Schedule of Benefits in Section XIII of this Contract.

4.4 Office Visit Allowance

We Cover Services provided in an office setting for diagnostic evaluation and treatment in full for each Member until the allowance described in the Schedule of Benefits in Section XIII of this Contract is exhausted for a Plan Year. Once the allowance is exhausted, the Cost-Sharing in the Schedule of Benefits will apply. Services included in the allowance are those provided by Your Primary Care Physician or Your Primary Care Physician whose specialty is exclusively internal medicine, family practice, general practice, OB/GYN, or pediatrics.

Preventive services required to be covered at no Cost-Sharing do not count towards the allowance.

4.5 Out-of-Pocket Limit

When You have met Your Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits in Section XIII of this Contract, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If other than Individual coverage applies, when members of the same family covered under this Contract have collectively met the family Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year.

4.6 Allowed Amount

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

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

See Section IV of the Contract for the Allowed Amount for an Emergency Condition.

SECTION V. WHO IS COVERED

5.1 Who is Covered Under this Contract

You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live, work, or reside in Our Service Area to be covered under this Contract. If You are eligible for Medicare, You are not eligible to purchase this Contract. If You selected one of the following types of coverage, members of Your family may also be covered.

5.2 Types of Coverage

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

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

5.3 Children Covered Under This Contract

If You selected Parent and Child/Children or Family coverage, "Children" covered under this Contract include Your natural Children, legally adopted Children, step-Children, and Children for whom You are

the proposed adoptive parent without regard to financial dependence, residency with You, student status, or employment. A proposed adopted Child is eligible for coverage on the same basis as natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate, and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this Section.

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

5.4 Open Enrollment

You can enroll under this Contract during an initial open enrollment period that runs from October 1, 2013 through March 31, 2014. If We receive Your selection between the first and fifteenth day of October, November, or December of 2013, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received by Us between the sixteenth and last day of the month of October, November or December of 2013, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then. If Your selection is received by Us between the first and fifteenth day of the month of January, February, or March of 2014, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received by US between the sixteenth and last day of the month of December 2013, January, February, or March of 2014, Your coverage will begin on the first day of the second month, as long as Your applicable premium payment is received by then.

You can enroll under this Contract during an annual open enrollment period that runs from October 15 through December 7. If We receive Your selection between these dates, Your coverage will begin on January 1 of the following year, as long as the applicable premium payment is received by then.

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

5.5 Special Enrollment Periods

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days of the occurrence of one of the following events:

- You or Your Spouse or Child loses minimum essential coverage.
- Your enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan or the Exchange.
- You adequately demonstrate to Us that another health plan in which You were enrolled substantially violated a material provision of its contract.

- You move and become eligible for new health plans;
- You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.
- You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions; or
- You, Your Spouse or Child exhausted Your COBRA or continuation coverage.

We must receive notice and We must receive any premium payment within 60 days of one of these events.

If You enroll because You lost minimum essential coverage or because You got married, Your coverage will begin on the first day of the month following Your loss of coverage or marriage.

If You have a newborn or adopted newborn Child and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have Individual or Individual and Spouse coverage You must also pay any additional premium for Parent and Child/Children or Family coverage within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise coverage begins on the date on which the We receive notice and the premium payment.

In all other cases, the effective date of Your coverage will depend on when We receive Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable premium payment is received by then.

5.6 Domestic Partner Coverage

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

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

- Neither individual has been registered as a member of another domestic partnership within the last six months; and

b. Proof of cohabitation (e.g., a driver's license, tax return, or other sufficient proof); and
c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
    - A joint bank account
    - A joint credit card or charge card
    - Joint obligation on a loan
    - Status as an authorized signatory on the partner's bank account, credit card, or charge card
    - Joint ownership of holdings or investments
    - Joint ownership of residence
    - Joint ownership of real estate other than residence
    - Listing of both partners as tenants on the lease of the shared residence
    - Shared rental payments of residence (need not be shared 50/50)
    - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
    - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
    - Shared household budget for purposes of receiving government benefits
    - Status of one as representative payee for the other's government benefits
    - Joint ownership of major items of personal property (e.g., appliances, furniture)
    - Joint ownership of a motor vehicle
    - Joint responsibility for child care (e.g., school documents, guardianship)
    - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
    - Execution of wills naming each other as executor and/or beneficiary
    - Designation as beneficiary under the other's life insurance Contract
    - Designation as beneficiary under the other's retirement benefits account
    - Mutual grant of durable power of attorney
    - Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
    - Affidavit by creditor or other individual able to testify to partners' financial interdependence
    - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI. COVERED SERVICES

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

6.1 Preventive Care
We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at 888-990-5702 ~~[315.432.9171]~~ or visit Our website at http://newyork.healthrepublic.us~~[www.newyorkcoop.org]~~ for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

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

6.1.2 Adult Annual Physical Examinations
We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the Covered preventive services is available on Our website at http://newyork.healthrepublic.us~~[www.newyorkcoop.org]~~, or will be mailed to You upon request.

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

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

6.1.3 Adult Immunizations

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

6.1.4 Well-Woman Examinations

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

6.1.5 Mammograms

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

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

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

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles, or Coinsurance.

6.1.6 Family Planning & Reproductive Health Services

We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the "Prescription Drug" benefit in Section VI of the Contract, counseling on use of contraceptives, related topics and sterilization procedures for women. Such services are not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies.

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

6.1.7 Bone Mineral Density Measurements or Testing

We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to Section VI of the Contract. Bone mineral density measurements or tests, drugs, or devices shall include

those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

6.1.8 Screening for Prostate Cancer

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic, and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age, for men having a prior history of prostate cancer.

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

6.2 PRE-HOSPITAL EMERGENCY MEDICAL SERVICES AND AMBULANCE SERVICES

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

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

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

- Placing the health of the person afflicted with such condition or, with
- respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

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

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable Copayment, Coinsurance, or Deductible.

Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

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

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

See the Schedule of Benefits in Section XIII of this Contract for any Preauthorization requirements for non-emergency transportation.

6.2.2 Limitations/Terms of Coverage
Benefits do not include travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician. Non-ambulance transportation such as ambulette, van or taxi cab is not Covered.
Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; **and** Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; **and** one of the following is met:

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

6.3 EMERGENCY SERVICES

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

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

We define an **Emergency Condition** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

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

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

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

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

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

- A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and
- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

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

6.3.1 Hospital Emergency Department Visits

In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition, as defined above, are Covered in an emergency department**. If You are uncertain whether this is the most appropriate place to receive care You can call Us before You seek treatment. Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

Follow-up care or routine care provided in a Hospital emergency department is not Covered. You should contact Us to make sure You receive the appropriate follow-up care.

6.3.2 Emergency Hospital Admissions

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

We Cover inpatient Hospital services at a Non-Participating Hospital at the In-Network Cost-Sharing for as long as Your medical condition prevents Your transfer to a Participating Hospital, unless We authorize continued treatment at the Non-Participating Hospital. If Your medical condition permits Your transfer to a Participating Hospital, We will notify You and arrange the transfer. Any inpatient Hospital services received from a Non-Participating Hospital after we have notified You and arranged for a transfer to a Participating Hospital will not be Covered. See Section IX of the Contract for Your Appeal rights.

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

You are responsible for any Deductible, Coinsurance, or Copayment.

6.4 URGENT CARE

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

A. In-Network
You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center.

B. Out-of-Network
We do not cover Urgent Care from Non-Participating Urgent Care Centers or Physicians in Our Service Area.

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

6.5 OUTPATIENT AND PROFESSIONAL SERVICES
(For other than Mental Health and Substance Use)

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

[6.5.1 Acupuncture
We cover acupuncture services (only for non-standard plans).]

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

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

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

6.5.5 Chemotherapy
We Cover Chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Section of this Contract.

6.5.6 Chiropractic Services
We Cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Contract.

6.5.7 Dialysis
We Cover dialysis treatments of an Acute or chronic kidney ailment.

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

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

6.5.8 Habilitation Services

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

6.5.9 Home Health Care

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

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

6.5.10 Interruption of Pregnancy

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

6.5.11 Infertility Treatment

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

- Basic Infertility Services. Basic Infertility Services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultra sound, hysterosalpingogram, sono-hystogram, testis biopsy, blood tests, and medically appropriate treatment of ovulatory dysfunction. Additional tests may be Covered if the tests are determined to be Medically Necessary.
- Comprehensive Infertility Services . If the Basic Services do not result in increased fertility, We Cover Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.
- Exclusions and Limitations
    a. In vitro, GIFT, and ZIFT procedures.
    b. Cost for an ovum donor or donor sperm.
    c. Sperm storage costs.
    d. Cryopreservation and storage of embryos.
    e. Ovulation predictor kits.
    f. Reversal of tubal ligations. Reversal of vasectomies.
    g. All costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers).
    h. Sex change procedures.

i. Cloning.
j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.
k. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

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

6.5.13 Laboratory Procedures, Diagnostic Testing and Radiology Services
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

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

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

6.5.15 Medications for Use in the Office: We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes.

6.5.16 Office Visits
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

6.5.17 Outpatient Hospital Services
We Cover Hospital services and supplies as described in the Inpatient Hospital Section that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy, and cardiac rehabilitation. **Please remember**, unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

6.5.18 Preadmission Testing
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that: the tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed; reservations

for a Hospital bed and operating room were made prior to the performance of the tests; surgery takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.

6.5.19 Rehabilitation Services

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

We Cover speech and physical therapy only when:

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

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

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

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

6.5.20 Second Opinions

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

6.5.21 Surgical Services

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies,

incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

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

- Through the Same Incision. If Covered multiple surgical procedures are through the same incision, We will pay for the procedure with the highest Allowed Amount.

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

6.5.22 Oral Surgery

We Cover the following limited dental and oral surgical procedures:

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

6.5.23 Reconstructive Breast Surgery

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

6.5.24 Other Reconstructive and Corrective Surgery

We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when:

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

6.5.25 Transplants

We Cover only those transplants determined to be nonexperimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and

bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

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

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. The medical expenses of a non-Member acting as a donor for You are not Covered if the non-Member's expenses will be Covered under another health plan or program.
We do not Cover travel expenses, lodging, meals, or other accommodations for donors or guests. We do not Cover donor fees in connection with organ transplant surgery. We do not Cover routine harvesting and storage of stem cells from newborn cord blood.

6.6 ADDITIONAL BENEFITS, EQUIPMENT, AND DEVICES

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

6.6.1 Autism Spectrum Disorder

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

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

  Repair, replacement fitting and adjustments of such devices are Covered when made necessary by normal wear and tear or significant change in Your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered ; however, We will Cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your

current functional level. We will not provide Coverage for delivery or service charges or for routine maintenance.

- **Behavioral Health Treatment:** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

  Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.
- **Psychiatric and Psychological Care**: We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.
- **Therapeutic Care:** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder, and when the services provided by such Providers are otherwise Covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.
- **Pharmacy Care**: We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Contract.

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

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

Nothing in this Contract shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services

pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

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

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

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

6.6.4 Self-Management Education
Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in your self-

management education; or when a refresher course is necessary. It must be provided in accordance with the following:

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

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

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

6.6.7 Durable Medical Equipment
Durable Medical Equipment is equipment which is:

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

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

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

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

6.6.9 Hearing Aids
We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

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

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

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

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

6.6.10 Hospice

Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

6.6.11 Medical Supplies

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

6.7 PROSTHETICS

6.7.1 External Prosthetic Devices

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this Section of the Contract and are only covered under the "Pediatric Vision" benefit in Section VI in this Contract. We do not Cover orthotics.

For adults, We Cover the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

Coverage is for standard equipment only. We do not otherwise Cover the cost of repairs or replacement.

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

6.7.2 Internal Prosthetic Devices

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.

6.8 INPATIENT SERVICES

(For other than Mental Health and Substance Use)

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

6.8.1 Hospital Services

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

- Semiprivate room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and cystoscopic rooms and equipment;
- The use of intensive care, special care, or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations, and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech, and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

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

6.8.2 Observation Services

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

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

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

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

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

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

We Cover speech and physical therapy only when:

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

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

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

6.8.8 Skilled Nursing Facility
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent, or domiciliary care is not Covered (see the “Exclusions and Limitations” Section of this Contract). An admission to a Skilled

Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to ~~200~~ 365 days, per Plan Year, for non-custodial care.

6.8.9 End of Life Care
If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Contract until the External Appeal Agent renders a decision in Our favor.

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

1. We will reimburse a rate that has been negotiated between Us and the Provider.

2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare acute care service rates.

3. Or if it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare rates.

6.8.10 Limitations/Terms of Coverage

1. When You are receiving inpatient care in a Hospital or other Facility as described above, We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.

2. We do not Cover radio, telephone, and television expenses, or beauty or barber services.

3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

6.9 MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES

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

6.9.1 MENTAL HEALTH CARE SERVICES

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

B. Outpatient Services

We Cover outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such Coverage is limited to Facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a Facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker ~~who meets the requirements of NY Ins. Law §§ 3221(l)(4)(D), 4303(h)(1)~~; or a professional corporation or a university faculty practice corporation thereof.

C. Limitations/Terms of Coverage

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

6.9.2 SUBSTANCE USE SERVICES

A. Inpatient Services

We Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes Coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs.

B. Outpatient Services

We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such Coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV, and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

We also Cover up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Contract that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

6.10 PRESCRIPTION DRUG COVERAGE

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

6.10.1 Covered Outpatient Prescription Drugs

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

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

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.
- Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the Infertility Section of this Contract.
- Off-Label Cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at http://newyork.healthrepublic.us/formulary~~[www.newyorkcoop.org]~~. You may also inquire if a specific drug is Covered under this Contract by contacting us at the number on Your ID card.

6.10.2 Refills
We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider, and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits in Section XIII of this Contract.

6.10.3 Benefit and Payment Information

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

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

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

   You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

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

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

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at 888-990-5702 ~~[315.432.9171]~~ or visit our website at http://newyork.healthrepublic.us ~~[www.newyorkcoop.org]~~ to request approval.

C. **Non-Participating Pharmacies:** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

D. **Designated Pharmacies:** If You require certain Prescription Drugs including, but not limited to, specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

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

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

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

- Age related macular edema
- Anemia, neutropenia, thrombocytopenia
- Contraceptives
- Crohn's Disease
- Cystic Fibrosis
- Cytomegalovirus
- Endocrine disorders/Neurologic disorders such as infantile spasms
- Enzyme Deficiencies/Liposomal Storage Disorders
- Gaucher's Disease
- Growth Hormone
- Hemophilia
- Hepatitis B, Hepatitis C
- Hereditary Angioedema
- HIV/AIDS
- Immune Deficiency
- Immune Modulator
- Infertility
- Iron Overload
- Iron Toxicity
- Multiple Sclerosis
- Oral Oncology
- Osteoarthritis
- Osteoporosis
- Parkinson's Disease
- Pulmonary Arterial Hypertension
- Respiratory Condition
- Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis,Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
- Transplant
- RSV Prevention

E. **Mail Order:** Certain Prescription Drugs may be ordered through Our mail order supplier. We will only cover maintenance drugs through a mail order pharmacy. Other drugs may also be purchased at a mail order pharmacy. You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

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

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

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

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at http://newyork.healthrepublic.us/formulary~~[www.newyorkcoop.org]~~ or by calling the Customer Service number on Your ID card. The maintenance drug list is updated periodically. Visit our website or call the Customer Service number on Your ID card to find out if a particular drug is on the maintenance list.

F. **Tier Status:** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at http://newyork.healthrepublic.us ~~[www.newyorkcoop.org]~~ or by calling the Customer Service number on Your ID card.

G. **When a Brand-Name Drug Becomes Available As a Generic:** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in Section IX of the Contract.

H. **Supply Limits:** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply. However, for maintenance drugs we will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for one Cost-Sharing amount; up to three Cost-Sharing amounts for a 90-day supply at a retail pharmacy.

Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two and a half Cost-Share amounts for a 90-day supply. We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail

pharmacy when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a Participating mail order pharmacy.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at http://newyork.healthrepublic.us ~~[www.newyorkcoop.org]~~ or by calling Customer Service at the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to Section IX of the Contract.

I. **Cost-Sharing for Orally-Administered Anti-cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits in Section XIII of this Contract or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under Section VI of this Contract.

6.10.4. Medical Management

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

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

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

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

C. **Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at ~~[www.newyorkcoop.org]~~http://newyork.healthrepublic.us or call the Customer Service at the phone number on Your ID Card.

6.10.5 Limitations/Terms of Coverage

A. We reserve the right to limit quantities, day supply, early Refill access, and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

B. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You don't make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

C. Compounded Prescription Drugs will be Covered only when they contain at least one ingredient that is a Covered Prescription Drug, are Medically Necessary, and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs require You to obtain Preauthorization.

D. Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

J. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies are not Covered under this Section but are Covered under other Sections of this Contract.

K. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under Section VI of this Contract.

L. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs or as otherwise provided in this Contract.

M. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

N. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

O. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

P. Your benefit for insulin, diabetic Prescription Drugs, supplies, and equipment is not provided under this Section of the Contract and is Covered under Section VI of the Contract. Your benefit for insulin and diabetic Prescription Drugs, supplies and equipment will be provided under this Section of the Contract if the Cost-Sharing is more favorable to You under this Section of the Contract than the Cost-Sharing under Section XIII of the Contract.

Q. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in Section IX of this Contract.

R. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

S. We do not Cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products, except as described under the Covered Outpatient Prescription Drug Section.

6.10.6. General Conditions

A. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug, or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

B. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may, from time-to-time, also enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors, or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

6.10.7 DEFINITIONS

Terms used in this Section are defined as follows. (Other defined terms can be found in the "Definitions" Section of this Contract).

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

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

Formulary: The list that identifies those Prescription Drugs for which Coverage may be available under this Contract. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at http://newyork.healthrepublic.us[~~www.newyorkcoop.org~~]/formulary or by calling the Customer Service number on Your ID card.

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

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

Participating Pharmacy: A pharmacy that has:

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

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

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

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

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

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

6.11 WELLNESS BENEFITS

Exercise Facility Reimbursement
We will partially reimburse the Subscriber and the Subscriber's Covered Spouse for certain exercise facility fees or membership fees, but only if such fees are paid to exercise facilities that We have an agreement with, and which maintain equipment and programs that promote cardiovascular wellness.

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

In order to be eligible for reimbursement, You must:

- be an active member of the exercise facility, and
- complete 50 visits in a six-month period.

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

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

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of $200 for the Subscriber and $100 for the Subscriber's Spouse or the actual cost of the membership per six-month period.

6.12 PEDIATRIC VISION

Pediatric Vision Care

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

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

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

- Case history;
- External examination of the eye or internal examination of the eye;
- Opthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and

- Summary findings and recommendation for corrective lenses.

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

SECTION VII. EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Contract for the following:

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

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

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

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

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

7.6 Experimental or Investigational Treatment

We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Contract for non-investigational treatments. See Section IX of this Contract for a further explanation of Your Appeal rights.

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

7.8 Foot Care
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, except as specifically listed in this Contract. For foot care related to diabetes, see Section VI of this Contract.

7.9 Government Facility
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law, unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

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

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

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

7.13 No-Fault Automobile Insurance
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

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

7.15 Services Provided by a Family Member
We do not Cover services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your spouse.

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

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

7.18 Vision Services
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in Section VI of this Contract.

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

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

SECTION VIII. CLAIM DETERMINATION

8.1 Claims

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

8.2 Notice of Claim

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website at http://newyork.healthrepublic.us ~~[www.newyorkcoop.org]~~. Completed claim forms should be sent to the address in Section II of this Contract or on Your ID card.

8.3 Timeframe for Filing Claims

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible.

8.4 Claims for Prohibited Referrals

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

8.5 Claim Determinations

Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies

to Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to Section IX of this Contract.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see Section IX of this Contract.

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

8.6 Pre-service Claim Determinations
If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

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

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

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

SECTION IX. GRIEVANCE, UTILIZATION REVIEW, & EXTERNAL APPEALS

9.1 GRIEVANCES

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

9.1.1 Filing a Grievance

You can contact Us by phone at ~~[315.432.9171 or~~ 888-990-5702~~]~~ or in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when you received the decision you are asking Us to review to file the Grievance.

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

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

9.1.2 Grievance Determination

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

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided Within 72 hours of receipt of Your Grievance.

Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for service.)	In writing, within 30 calendar days of receipt of Your Grievance.

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

Call the New York State Department of Financial Services at
1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

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

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

9.2 UTILIZATION REVIEW

9.2.1 Utilization Review

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

All determinations that services are not Medically Necessary will be made by licensed Physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not or were not Medically

Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, You can contact Us or visit our website at http://newyork.healthrepublic.us.~~[www.newyorkcoop.org].~~

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

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

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

After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

9.2.4 Concurrent Reviews
Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of all necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of Our receipt of the information or, if We do not receive the information, within 1 business day of the end of the 45-day time period.

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

9.2.6 Retrospective Reviews

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

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

9.2.7 Retrospective Review of Preauthorized Services

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

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

9.2.8 Reconsideration

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

9.2.9 Utilization Review Internal Appeals

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

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

- A statement from Your attending Physician, who must be a licensed, board-certified, or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested Out-of-Network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and

- Two documents from the available medical and scientific evidence that the Out-of-Network service:
  (a) Is likely to be more clinically beneficial to You than the alternate In-Network service; and
  (b) that the adverse risk of the Out-of-Network service would likely not be substantially increased over the In-Network health service.

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

9.2.10 Standard Appeal

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and, where appropriate, Your Provider, within two ~~[2]~~ business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

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

9.2.11 Expedited Appeals

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

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

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail: cha@cssny.org

I. YOUR RIGHT TO AN EXTERNAL APPEAL

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

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

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

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

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

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

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

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

- A service, procedure, or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your

condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

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

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

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

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

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

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

V. THE EXTERNAL APPEAL PROCESS

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

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

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

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

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

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

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

We will charge You a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

VI. YOUR RESPONSIBILITIES

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

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

SECTION X. TERMINATION OF COVERAGE

Coverage under this Contract may be terminated as follows:

1. Coverage under this Contract shall automatically be terminated on the first of the following to apply:
    a. Upon Your death, coverage under this Contract will terminate unless You have coverage for Dependents. If You have coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium has been paid.
    b. For Spouses in cases of divorce, the date of the divorce.
    c. For Children, until the end of the month in which the Child turns 26 years of age. For all other Dependents, the date in which the Dependent ceases to be eligible.

2. You may terminate coverage under this Contract at any time by giving Us at least 30 days prior written notice.

3. We may terminate coverage under this Contract on 30 days written notice as follows:
    a. For non-payment of Premiums. Premiums are to be paid by You to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
    If You fail to pay the required Premium within a 30 day grace period, coverage will terminate retroactively back to the last date Premiums were paid. You will be responsible to pay for any claims submitted during the grace period.
    b. If You have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on Your enrollment application or in order to obtain coverage for a service, coverage will terminate immediately upon a written notice to You from Us. However, if You make an intentional misrepresentation of material fact in writing on Your enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage and Your application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Contract.
    c. If You no longer live, reside, or work in Our Service Area.
    d. The date on which You cease to meet the eligibility requirements for coverage.

e. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide You with at least 90 days prior written notice.
f. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this state. We will provide written notice to You at least 180 days prior to when Your coverage will cease.

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

See Section XI of this Contract for Your right to conversion to an individual Contract.

SECTION XI. WHAT HAPPENS IF YOU LOSE COVERAGE

11.1 EXTENSION OF BENEFITS

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

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

11.1.1. When You May Continue Benefits

If You are totally disabled on the date Your coverage under this Contract terminates, We will continue to pay for Your care under this Contract during an uninterrupted period of total disability until the first of the following:

- The date You are no longer totally disabled.
- 12 months from the date this Contract terminated.

11.1.2. Limits on Extended Benefits

We will not pay extended benefits:

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

11.2 CONVERSION RIGHT TO NEW CONTRACT AFTER TERMINATION

The Subscriber's Spouse and Children have the right to convert to a new Contract if their coverage under this Contract terminates under the circumstances described below.

A. **Termination of Your Marriage.** If a Spouse's coverage terminates under Section X of this Contract because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.

B. **Termination of Coverage of a Child.** If a Child's coverage terminates under Section X of this Contract because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

C. **On the Death of the Subscriber.** If coverage terminates under Section X of this Contract because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

11.2.1 When to Apply for the New Contract

If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of Your coverage under this Contract. You must also pay the first Premium of the new Contract at the time You apply for coverage.

11.2.2 The New Contract

We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. You may choose among any of the four Policies offered by Us.

11.2.3 When Conversion is Not Available

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

11.2.4 Temporary Suspension Rights for Members of the Armed Forces If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

A. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and

B. You serve no more than five years of active duty.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned premiums will be refunded during the period of such suspension.

Upon completion of active duty:

Your coverage may be resumed as long as You make written application to Us and remit the premium within 60 days of the termination or active duty. The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XII. GENERAL PROVISIONS

1. **Agreements between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Contract does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. **Assignment.** You cannot assign any benefits or monies due under this Contract to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Contract or your right to collect money from us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. **Changes in This Contract.** We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.

4. **Choice of Law.** This Contract shall be governed by the laws of the State of New York.

5. **Clerical Error.** Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. **Continuation of Benefit Limitations.** Some of the benefits under this Contract may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

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

8. **Furnishing Information and Audit.** All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

9. **Identification Cards.** Identification cards are issued by Us for identification only. Possession of any identification card confers no right to services or benefits under this Contract. To be entitled to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.

10. **Incontestability.** All statements contained in any such written instrument shall be deemed representations and not warranties.

    No statement by You in an application for coverage under this Contract shall void the Contract or be used in any legal proceeding unless the application is or an exact copy is attached to this Contract. After two years from the date of issue of this Contract no misstatements, except for fraudulent misstatements made by the Subscriber in the application for coverage shall be used to void the Contract or deny a claim.

11. **Independent Contractors**. Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse, or Children while receiving care from any Participating Provider or in any Participating Provider's facility.

12. **Material Accessibility.** We will give You identification cards, Certificates, riders, and other necessary materials.

13. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Contract. Upon Your request, We will provide the following information:
    - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
    - The information that We provide the State regarding Our consumer complaints.
    - A copy of Our procedures for maintaining confidentiality of Member information.
    - A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Contract.
    - A written description of Our quality assurance program.
    - A copy of Our medical Contract regarding an experimental or investigational drug, medical device or treatment in clinical trials.
    - Provider affiliations with Participating Hospitals.
    - A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review

guidelines.

14. **Notice.** Any notice that We give to You under this Contract will be mailed to Your address as it appears on our records. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: [Health Republic Insurance of New York, 30 Broad Street, 34th Floor, New York NY 10004. You may also upload it via the secured member section of our website at http://newyork.healthrepublic.us.112 West 34th Street, Suite 17058, New York, New York 10120.]

15. **Premium Payment**: The initial premium is payable one month in advance by You to Us at Our office. The first month's premium is due and payable upon submission of the application. Coverage will begin on the effective date of the Contract as defined herein. Subsequent premiums are due and payable on the first of each month thereafter.

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

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

18. **Renewal Date.** The renewal date for the Contract is January 1 of each Year. This Contract will automatically renew each year on the renewal date unless otherwise terminated by Us as permitted by the Contract, or by You upon 30 days' prior written notice to You.

19. **Reinstatement After Default.** If You default in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers 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.

20. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will make or will not make payments under this Contract. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether surgery was Medically Necessary to treat Your illness or injury; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Contract.

21. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

22. **Severability.** The unenforceability or invalidity of any provision of the Contract shall not affect the validity and enforceability of the remainder of the Contract.

23. **Significant Change in Circumstances**. If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

24. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness, or other condition and We have provided benefits related to that injury, illness, or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Contract. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

    Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

    We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

25. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within 2 years from the date the claim was required to be filed.

26. **Translation Services.** Translation services are available under this Contract for non-English speaking Members. Please contact us at 888-990-5702 ~~[315.432.9171]~~ to access these services.

27. **Venue for Legal Action.** If a dispute arises under this Contract, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere

else. You also consent to these courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order You to defend any action We bring against You.

28. **Waiver.** The waiver by any party of any breach of any provision of the Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

29. **Who May Change This Contract.** The Contract may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer (CEO) or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

30. **Who Receives Payment under This Contract.** Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

31. **Workers' Compensation Not Affected.** The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

32. **Your Medical Records and Reports.** In order to provide Your coverage under this Contract, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Contract, You automatically give Us or our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:
    - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
    - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
    - Permit copying of Your medical records by Us.

    We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

Freelancers Health Service Corporation
Individual Comprehensive Medical Business
Rate Filing Justification
Part III - Actuarial Memorandum and Certification

This document contains the Part III Actuarial Memorandum for Freelancers Health Service Corporation's (FHSC's) individual comprehensive medical block of business, effective January 1, 2014. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered in the Part I URRT (which supports compliance with the market rating rules and reasonableness of applicable rate increases). This memorandum may not be appropriate for other purposes.

The information in this actuarial memorandum is intended for use by the New York Department of Financial Services and the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of FHSC's individual medical rate filing. However, we recognize this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed to place no reliance upon this actuarial memorandum prepared for FHSC by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

I. General Information

Company Identifying Information

Company Legal Name:	Freelancers Health Service Corporation
State:	New York
HIOS Issuer ID:	71644
Market:	Individual
Effective Date:	January 1, 2014

Company Contact Information

Primary Contact Name:	[redacted]
Primary Contact Telephone Number:	[redacted]
Primary Contact Email-Address:	[redacted]

Consultant Contact Information

Primary Contact Names:	[redacted]
Primary Contact Telephone Number:	[redacted]
Primary Contact Email-Address:	[redacted]

II. Proposed Rate Increase(s)

This submission is for new individual medical products available for sale January 1, 2014. FHSC does not currently sell individual medical plans. As such, there is no proposed rate increase on current products.

III. Experience Period Premium and Claims

There is no historical experience illustrated in Worksheet 1, Section I of the URRT since FHSC does not currently sell individual medical plans.

Claims Paid Through Date

Not applicable.

Premiums (net of MLR Rebate) in Experience Period

Not applicable.

Allowed and Incurred Claims Incurred During the Experience Period

Not applicable.

IV. Benefit Categories in Worksheet 1, Section II of the URRT

Experience: There is no experience period claim information by benefit category since FHSC does not currently sell individual medical plans

Credibility Manual: We categorized utilization and cost information by benefit using *Milliman's Health Cost Guidelines* (HCGs) categories since no prior claim experience is available for this product. Milliman's categories are assigned based on place and type of service using a detailed claims mapping algorithm summarized as follows:

- Inpatient Hospital (facility charges with an overnight stay)
- Outpatient Hospital (facility charges without an overnight stay)
- Professional (services billed separately from facility claims associated with a given inpatient hospital stay or outpatient procedure)
- Other Medical (with units measured as a mix of visits, cases, procedures, etc.)
- Capitation (services for which FHSC does not take risk, but pays another provider based on members served)
- Prescription Drug (Prescriptions not billed by a facility or professional)

V. Projection Factors Applied to Experience

There are no experience projection factors in Worksheet 1, Section II of the URRT since FHSC does not currently sell individual medical plans.

VI. Credibility Manual Rate Development

FHSC's rates are based 100% on manual rates since FHSC is new to the individual market in 2014 and has no prior experience.

Source and Appropriateness of Experience Data Used

Source: The credibility manual rate utilization and unit costs shown in Worksheet 1, Section II of the URRT are based on Milliman's *Health Cost Guidelines* (HCGs) calibrated to the New York market place.

Appropriateness: The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs are continually monitored against other data sources and have been updated and expanded annually since that time.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience, and establish interrelationships between different health coverages.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

Adjustments Made to Milliman's HCGs

We adjusted Milliman's HCG estimates (to more accurately reflect projected 2014 FHSC experience) for:

<u>Morbidity (a.k.a., Adverse Selection)</u>

We expect significant morbidity changes in the insured population when the health insurance Exchange opens in 2014. We performed the following steps to estimate the morbidity of 2014 insured members.

Step 1: We estimated New York's current total population and their associated health status by insured status. The statewide market estimates are based on the population at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) from the U.S. Census provides state-level data for each of these strata. We adjusted the raw CPS data after reviewing the following additional data sources:

- Carriers' annual statutory financial filings provided to the NAIC. The filings contain reliable sizes of the individual and fully insured group markets.

- The Medicaid Statistical Information System (MSIS) (available through the Department of Health and Human Services), which provides reliable data on Medicaid enrollment in New York.

Step 2: We trended the entire population to 2014 based on projected population growth rates.

Step 3: We projected the number of individuals that will purchase individual insurance in the Exchange and non-Exchange markets (i.e., "take-up" rates) from all population categories. Our Exchange take-up rate assumptions are primarily driven by a person's current insurance status (i.e., insured or uninsured), limited incentives to purchase coverage when healthy (i.e. the least healthy members will be the first to apply for coverage), and the federal subsidy available (if any) if the member enrolls in an Exchange plan. This resulted in a 2014 population projection by

cohort (i.e., age, gender, income, and Exchange status). Finally, we applied a smoothing algorithm to compensate for potential credibility issues. We estimate 2014 average claim costs across the New York market will decline approximately 15% vs. the current individual market based on a combination of current population data, various industry studies, and proprietary data.

Step 4: We recalculated the resulting average health status of FHSC's share of the individual market based on the migration described in Step 3. We projected FHSC's expected 2014 individual product enrollment on and off the exchange based on our estimate of the statewide population and FHSC's likely share of the total insured market based on their relative prices and general appeal. We estimated the members that would select each of FHSC's benefit plans based on the plans for which they would qualify (given their age and income level). We assumed all 2014 members are enrolled for the entire year.

Step 5: We adjusted our base experience (from Milliman's HCGs) for the difference between FHSC's newly projected individual population's 2014 health status relative to the large group's current average health status.

The resulting morbidity adjustment of 0.866 is shown in Exhibit 8, line 17. This factor does not include the impact of changes in demographics to ensure that demographic shift is not counted twice.

Benefits

The underlying utilization and charge levels assumed in the Milliman *Health Cost Guidelines* baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $2,000 out-of-pocket maximum. We adjusted the HCGs to reflect:

- Utilization and cost changes the total insured population would exhibit due to benefit plan cost sharing levels (a.k.a., induced demand or benefit richness, not including health status), and

- Federal and State mandated benefits (e.g., EHBs not reflected in the HCGs).

These adjustments were based on Milliman research on the historical impact of different contractual limitations and cost sharing on experience.

Demographics

We are projecting a change in demographics in the insured population when the health insurance Exchange opens in 2014. We projected New York statewide population and FHSC's demographics and adjusted these data to be on a basis consistent with FHSC's projected 2014 demographics.

Trend

Manual rates were trended forward to a January 1, 2014 effective date using the service-specific utilization and unit cost trends in Worksheet 1, Section II. The service-specific factors reflect an aggregate allowed charge trend of 5%. These trends were estimated based on Milliman research, general industry knowledge, and our judgment of recent trends. They reflect "secular trend (i.e., utilization, unit cost, and mix – a.k.a., intensity of service change) and the average aging of the population. They do not reflect population mix changes, adverse selection, or deductible leveraging.

Other

We adjusted our underlying HCG manual claims data to reflect FHSC's projected experience in 2014 for other factors including, but not necessarily limited to:

- Geographic Area (to reflect FHSC-specific utilization and billed charges). The geographic area factors are based on FHSC's provider reimbursement contracts by region and Milliman's HCGs. These geographic are factors are in compliance with HHS proposed regulations. Specifically, the factors represent geographic differences in claims due to provider network characteristics, delivery system characteristics, and utilization management practices. The geographic area factors do not reflect differences in age, sex, occupation, or health status.

- Unit costs (to reflect FHSC-specific provider discounts), and

Inclusion of Capitation Payments

All covered services are included in the manual rate development described. In building the rate manual, historical capitation payments were included in the underlying claim experience used to develop relative values against the HCGs. As such, relevant capitation payments are included in the applicable service categories.

The Milliman HCGs are based on nationwide claim experience, which include all appropriate incurred and allowed claims. These data include relevant capitation payments as part of the underlying claim experience. The exception is the pediatric dental benefit, which is included in the "Capitation" line in the credibility manual rate.

Portion of Cost Payable by HHS's Fund on Behalf of Insureds

Because of the cost sharing reduction (CSR) provisions, HHS will pay a portion of these costs on behalf of members. We have estimated these costs based on our estimated enrollment of CSR eligible members. For the applicable plan, we estimate the CSR based on the following formula:

(CSR Plan AV – Base Silver Plan AV) * Induced Demand for CSR Plan AV * Base Silver Allowed Charges

Per final rules, the induced demand for the CSR Plan AV equals 1.12 for 87% and 94% AV plans and 1.00 for 73% AV plans. Note that the AVs used in the formula above are the theoretical target AVs (e.g. 70% for the base silver).

We have expressed this amount as a percentage of cost, in Worksheet 2.

VII. Credibility of Experience

FHSC's rates are based 100% on manual rates since FHSC is new to the individual market in 2014 and has no prior experience.

VIII. Paid to Allowed Ratio

The Paid to Allowed ratio shown in Worksheet 1, Section II of the URRT was developed as follows:

$$\frac{\sum_{i=1}^{\infty} \text{Projected Paid Claim PMPM}_i \times \text{Projected Members}_i}{\sum_{i=1}^{\infty} \text{Projected Allowed Claim PMPM}_i \times \text{Projected Members}_i}$$

where i = benefit plan and PMPM = per member per month. Projected members in the above equation are displayed in Worksheet 2, Section IV of the URRT.

IX. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

We assumed FHSC's risk score will equal the state average and therefore did not include any risk adjustment payments or receipts in our pricing.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

We estimated ACA reinsurance recoveries net of the $5.25 PMPM reinsurance contribution will be $39.70 PMPM. The recoveries assume FHSC will receive 80% of all individual members' per member per year incurred claims between $60,000 and $250,000. The net payment was allocated by plan in proportion to premium as required by CMS.

We estimated the recoveries using Milliman's HCG's claim probability distributions (CPDs) calibrated to each of FHSC's basic individual benefit plans' estimated PMPM claims by age, income as a percent of the federal poverty level (FPL), and on/off exchange status. CPDs are a frequency distribution of claim amounts that can be used to estimate PMPM claims between various deductibles and stop-loss amounts.

X. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

We estimate FHSC's administrative expenses to be $60.58 PMPM (excluding taxes and fees). This estimate is entered as a percent of premium that does not vary by plan in Worksheet 1, Section III of the URRT. It is based on a detailed budget projection of all expenses. We adjusted the budget amount for ACA implementation expenses. There was no allocation of corporate overhead as health coverage is FHSC's only line of business. This amount does not include any profit, risk load, taxes, or assessments described below.

Target Contribution to Surplus (a.k.a., Profit) & Risk Load

We built in -2.7% of premium for a target contribution to surplus that does not vary by product or plan. We did not build in any additional loads for profit or risk. This loss is consistent with FHSC's business plan and feasibility study supporting its federal loan funding. FHSC expects to be

profitable once it achieves critical mass. FHSC has secured federal loans of $174 million that will allow it to maintain appropriate surplus levels in its early years of operations.

Taxes and Fees

Table 1 displays the projected taxes and fees that may be subtracted from premiums when calculating FHSC's loss ratio for MLR purposes (with the exception of the $5.25 federal reinsurance fee that is shown net of reinsurance recoveries and not in this section). The composite value is displayed in Worksheet 1, Section III of the URRT.

Table 1 Projected Taxes and Fees		
Item	**PMPM**	**% Prem**
Premium Tax		1.75%
State Assessments		3.83%
Reinsurance Operating Fee	$0.11	
Research Trust Fund Fee	$0.17	
Risk Adjuster Administrative Fee	$0.08	
Exchange User Fee	Not built into the rates per New York instructions	

XI. Projected Loss Ratio

The projected ACA loss ratio based on federally prescribed MLR methodology, excluding adjustments for credibility, is 88.4%. This includes an estimate for quality improvement/cost containment programs as described in Attachment D.

The projected loss ratio using New York's projected MLR method is 82.4%. We assumed NY's projection method MLR equals the following:

NY MLR = (Incurred Claims + State Assessments – Reinsurance Recoveries) / Earned Premium

XII. Index and Plan Rates

Index Rate Development

The index rates represent the estimated total combined allowed PMPM claims of all non-grandfathered plans within FHSC's individual New York market. These index rates have not been adjusted for risk adjustment transfers, reinsurance fees/recoveries, or Exchange fees.

Experience Index Rate: We did not enter an experience index rate in Worksheet 1, Section I of the URRT since FHSC does not currently sell individual medical plans.

Difference Between Total Allowed Claims PMPM and Index Rate: There is no difference between the total allowed PMPM claims and the index rate in Worksheet 1, Section I of the URRT since neither value is provided due to FHSC not having experience.

Projected Index Rate: The projected index rate shown on the first line of Worksheet 1, Section III of the URRT contains only EHBs and no additional benefits. It is equal to the credibility manual rate since FHSC has no experience to weight with the credibility manual rate.

Non-EHB Adjustment: We did not make an adjustment for non-EHBs since FHSC's benefit plans only cover EHBs (i.e., there are no additional benefits beyond the EHBs in the PCMIR).

Plan Rate Development

We developed plan rates by first calculating an adjusted index rate, then the plan-specific rates as follows:

Adjusted Index Rate equals the:

Index Rate + Risk Adjustment Payment (Receipt) + Reinsurance Recoveries net of Fees + Exchange User Fees

The plan rate equals the Adjusted Index Rate multiplied by the following plan-specific values with a "Yes" in Table 2 below:

Table 2
FHSC Individual Business in New York
Plan-Specific Adjustments Made to the Adjusted Index Rate

Allowed Plan-Specific Adjustment	Is Adjusted Index Rate Multiplied by this Factor?
Actuarial value and cost sharing design of the plan	Yes
Provider network, delivery system characteristics, and utilization management practices	Yes
Benefits in addition to the EHBs (pooled with similar benefits in the single risk pool)	No
Administrative costs (not including the exchange user fees)	Yes
Catastrophic plan expected impact of the specific eligibility categories [1]	Yes

[1] Reflects only the difference in expected demographics between the catastrophic plan and non-catastrophic plans (i.e., metal plans). No additional morbidity adjustments were made for these plans.

With respect to the catastrophic plan, we compared the base rate for a distribution of policyholders primarily under age 30 vs. the standard distribution of issues across all ages. This is based on our belief that the catastrophic plans are likely to attract a young, healthy population seeking minimal coverage, yet still meeting the individual mandate.

Conversion of Plan Rates to Composite Rates (Required by New York)

New York requires rates not vary by age (i.e., composite rating). We converted the average PMPM rate by plan to composite rates using the following formula:

Plan-Specific PMPM Index Rate x Conversion Factor = Single Rate

$$\text{Conversion Factor} = \frac{\text{Weighted average members per contract for risk pool}}{\text{Weighted average rate relativity for all rating tiers in risk pool}}$$

FHSC's rates reflect the New York allowed rating tiers of employee only, employee and spouse, Employee and Child(ren) and Family (i.e., Employee, spouse, and child(ren)) and their state-mandated relative rate by tier.

XIII. AV Metal Levels

The AV Metal Values included in Worksheet 2, Section I of the URRT were developed using the CMS Actuarial Value calculator. Attachment A includes printouts of the AV calculator output for each of FHSC's plans. Attachment B includes a listing of all FHSC plans including:

- Whether on-exchange, off-exchange (or both)
- Product name
- Associated metal tier level
- Metal Actuarial Value
- Description of cost sharing features & benefits

XIV. AV Pricing Values

Fixed Reference Plan: The fixed reference plan used to develop the AV Pricing Values is the Standard Bronze Plan, (HIOS Plan ID 71644NY0010001).

Portion of the AV Pricing Value Attributable to Each of the Allowable Modifiers to the Index Rate: Attachment C provides a summary of the AV pricing values by plan (as displayed in Worksheet 2, Section I) with a breakdown of the components attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2), to arrive at the plan level rate.

Please note that we included induced demand adjustments within the Silver plan for the additional utilization anticipated when members under 250% FPL receive cost sharing reductions through alternative Silver plans. However, we limited the induced demand to the levels specified by New York based on the alternative Silver plans' AVs. Section XV includes a membership distribution of alternative Silver plan membership.

Utilization Adjustments Due to Cost Sharing Among Plans Excludes Health Status: The impact of each plan's actuarial value and cost sharing adjustment includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the health status (a.k.a., morbidity) of the members assumed to select the plan. We used Milliman's HCGs to estimate how members purchase services differently based on the amount of plan-specific cost-sharing. The HCG adjustments assume the same demographic and risk characteristics for each plan priced and therefore exclude expected differences in the morbidity of members assumed to select the plan.

XV. Membership Projections

Considerations in Projecting the Total Membership: FHSC projected membership (as displayed in Worksheet 2, Section IV of the URRT) by considering the size of the projected New York individual market in 2014 and an assumed penetration rate of this market. The size of the market was estimated based on the current size of the New York individual market adjusted for additional consumers buying if carriers offer rates that are lower than those currently in the market, the individual mandate, the lack of Medicaid expansion, and the lack of the Basic Health Plan.

Differences vs. Current: We made no comparison of the projections to current since FHSC does not currently insure members in the New York individual market.

Methodology to Project Cost Sharing Reduction (CSR) Eligibles: We projected CSR eligibles by first estimating the breakdown by income (i.e., Federal Poverty Level – FPL) of the total individual

market purchasing coverage. Next, we assumed members eligible for cost sharing subsidies will select the richest benefit plan for which they qualify at their projected FPL.

Projected Cost Sharing Reduction (CSR) Eligibles: Table 3 displays the distribution and projected members for all the Silver plans, including the alternate Silver plans for which CSR eligibles can purchase.

Table 3
Assumed Member Distribution Across Silver Metal Tier

Silver Plan	Plan Level	Assumed Member Distribution	Projected Members
New York Standard Silver	94%	10.4%	1,933
	87%	40.7%	7,551
	73%	28.4%	5,268
	70%	20.4%	3,787

XVI. Terminated Products

FHSC does not have any terminated products since they do not currently sell individual medical plans.

XVII. Plan Type

The applicable plan type for each plan has been noted in Worksheet 2, Section I of the URRT.

XVIII. Warning Alerts

The following two warning alerts appear in Worksheet 2, Section IV of the URRT:

- Total Premium (TP) – The formula generating the comparison does not allow for marginal rounding errors. Also, the capitation line in Worksheet 1 does not allow values of 0 in utilization and average cost and therefore, we needed to put in 1's which produce $30 extra premium in Worksheet 2.

- Total Allowed Claims (TAC) - It appears the warning is due to an incorrect comparison in the URRT. The URRT compares the Total Allowed Claims before reinsurance or risk adjustments from Worksheet 2 to the Allowed Claims after the impact of reinsurance and risk adjusters from Worksheet 1. As such, we would not expect these two values to match.

XIX. Reliance

In preparing the Part I Unified Rate Review Template (URRT) and Part III Actuarial Memorandum, I have relied on information provided to me by the FHSC management and its affiliates. To the extent that it is incomplete or inaccurate, the contents of the URRT and Actuarial Memorandum along with many of our conclusions may be materially affected.

A data reliance letter is attached to this rate submission as Attachment E.

XX. Actuarial Certification

I am a Consulting Actuary with the firm of Milliman, Inc. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. This filing is prepared on behalf of FHSC.

I certify to the best of my knowledge and judgment:

1. The projected index rate is:

   - In compliance with all applicable State of New York and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
   - Developed in compliance with the applicable Actuarial Standards of Practice,
   - Reasonable in relation to the benefits provided and the population anticipated to be covered, and
   - Neither excessive nor deficient based on my best estimates of the 2014 individual market.

2. The index rate and only allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

3. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

4. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the Part I Unified Rate Review Template for all plans.

5. The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

   a. ASOP No. 5, Incurred Health and Disability Claims
   b. ASOP No. 8, Regulatory Filings for Health Plan Entities
   c. ASOP No. 12, Risk Classification
   d. ASOP No. 23, Data Quality
   e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
   f. ASOP No. 41, Actuarial Communications

6. The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;

7. The benefits are reasonable in relation to the premiums charged; and

8. The rates are not unfairly discriminatory.

The Part I Unified Rate Review Template (URRT) does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided

in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The information provided in this actuarial memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop propose premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

The results are actuarial projections. Actual experience will differ for a number of reasons including, but not necessarily limited to, population changes, claims experience, and random deviations from assumptions.

Respectfully submitted,

[redacted]

FREELANCERS
HEALTH SERVICE
CORPORATION

April 23, 2013

RE: Freelancers Health Service Corporation 2014 Individual and Small Group Pricing

Dear Scott:

I, Allison Silvers, Director of Operations for Freelancers Health Service Corporation (FHSC), hereby affirm the data sources, assumptions, and information identified below and provided to Milliman, Inc. were prepared under my direction, and these items relied upon are to the best of my knowledge accurate and complete. Finally, I affirm all information that affects the actuarial items examined has been given to you, and I have disclosed all items of which I am aware that would have a material impact on the rate projections.

The information provided includes:

1. Benefit plans FHSC intends to offer in 2014,
2. Product name, product id, and plan name as entered in HIOS for each benefit plan,
3. Projected administrative expenses and profit,
4. The rating regions (as defined by New York) that FHSC intends to offer individual and small group products in 2014,
5. Guidance on appropriate trend factors for FHSC,
6. Guidance on appropriate medical management assumptions for FHSC's plans and provider networks,
7. Guidance on expected migration of uninsured, small group and large group to the individual market in 2014,

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8. Description of contractual provider reimbursement arrangements, and
9. Other information provided by FHSC in various meetings, phone calls, emails, and other correspondence

April 23, 2013

Date

[redacted]

Signature

4. Quality

In accordance with the Affordable Care Act, Freelancers Health Service Corporation (FHSC) will follow a comprehensive strategy to ensure the health and safety of its members, including all required aspects. Below is more detail on the quality strategy, delineated by requirements.

A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

FHSC, in collaboration with its vendors (POMCO for TPA and medical management, MagnaCare for its provider network and others), will actively seek to maximize health outcomes and assure quality care for all enrollees through its member-centric designed programs and services. Strategies that will be employed to achieve these goals include: Case Management for specified conditions, limited Disease Management, Utilization Management, member-based quality initiatives, and risk-based Medical Home contracting.

A detailed Quality Assurance Plan will be implemented under the direction of the Medical Director and will be monitored by the Board on a quarterly basis. The goals of the plan are to meet or exceed the standards developed under PPACA and the New York Health Benefit Exchange. In addition, the plan will map the steps towards preparation for NCQA or URAC Accreditation. Data for Quality Management will be assembled using the QARR reporting standards used by the New York State Department of Health.

When vendors are used for these activities, the vendor will collaborate with FHSC's Medical Director to regularly review outcomes and quality indicators, and devise specific initiatives to improve members' health outcomes and achieve optimal wellness. The Quality Strategy also leverages national and state-specific initiatives on patient safety and care coordination along with full participation in public health interventions for the benefit of our members.

Case Management

POMCO's URAC-accredited Case Management services will be employed for certain patient populations to improve the quality of patient care while maximizing cost savings. They will provide members with a better understanding of specialized care needs, facilitate treatment adherence, and provide education on alternatives to costly inpatient care

At this point, we anticipate employing specialized case management for the following:

- *Maternity/Neonates:* Maternity Case Management provides a continuum of care during pregnancy and offers additional education, management and negotiation with home health vendors during complicated pregnancies. Case Managers are extremely knowledgeable regarding the management of high-risk

pregnancies, premature babies, childhood diseases, treatments, growth and developmental stages. They provide education and support to expectant mothers in order to reduce instances of complications and subsequent high claims costs.

- *Psychiatric/Substance Abuse:* LMSW social workers and psychiatric nurses work with members to facilitate access to treatment, and adherence to the treatment plan. In addition they will identify community resources and help coordinate care with other providers.

- *Transplant:* Case Managers work with Transplant Centers of Excellence, financial coordinators, reinsurance carriers and claims offices to coordinate services for members throughout the entire continuum of transplant care.

Disease Management

FHSC will seek to provide targeted Disease Management services only for prevalent conditions for which evidence-based guidelines are established to impact health and measure improvements. We will trigger disease management services depending on the prevalence in our enrolled population; the potential disease states may include:

- Asthma (pediatric and adult);
- Diabetes (pediatric and adult);
- Congestive Heart Failure; and
- Chronic Obstructive Pulmonary Disease.

Both Comprehensive Disease Management and High-Risk Disease Management approaches will be evaluated for FHSC members. Comprehensive Disease Management will target all individuals identified with such conditions mentioned above, while High-Risk Disease Management would target those individuals who have been hospitalized at least once in the past six months.

The goals of the Disease Management program include improving participant activation and effecting improvements in the health status of participants by using Nurse Coaches to provide education, tools, and support that promote good self-care practices and adherence to evidence-based care guidelines. Examples of the potential disease management approaches include:

- Asthma – The asthma program will focus on increasing awareness of a member's symptoms and when they occur; encourages the use of a daily diary to track symptoms; addresses issues regarding diet and exercise; identification and remediation of asthma triggers in the home provides information about asthma medications and the importance of good medication management; addresses barriers members may have

with medication adherence; and works with members to identify causes of asthma symptoms and potential adjustments to reduce symptoms. The end result is a personalized asthma care plan that allows optimal coordination with the member's physician.

- Diabetes – The diabetes program will help members manage their diabetes and low blood sugar; provide education on targets for blood sugar, cholesterol and blood pressure; address the relationship between carbohydrates and blood glucose and ways to adjust carbohydrate intake; focuses on insulin self-management (if applicable); and helps build awareness of the importance of physical activity and healthy coping strategies. The personalized diabetes care plan allows for coordination of self-management and physician management of diabetes.

- Congestive Heart Failure – The Congestive Heart Failure program will provide education on heart health and how medications can work to treat Congestive Heart Failure; educate members on the self-identification of symptoms and behaviors that may cause the symptoms; help members identify opportunities to reduce symptoms through lifestyle changes such as diet and nutrition; utilize weight charts and symptom management plans that are coordinated with the member's physician.

- Chronic Obstructive Pulmonary Disease – The Chronic Obstructive Pulmonary Disease program will focus on educating members about the signs and symptoms of Chronic Obstructive Pulmonary Disease along with what activities can cause members to feel better or worse; encourages the use of a daily diary to track symptoms; provides education on oxygen therapy (if applicable) and on medications and how they should be taken; addresses opportunities for improving diet and nutrition; utilize self-monitoring strategies to coordinate with the members physician.

Potential Case Management and Disease management opportunities are identified during the notification review process using an automated, customizable trigger list based on ICD-9, CPT and dollar threshold criteria, along with nationally recognized criteria and systems, to flag a member's current medical situation. A case may also be flagged when a member's length-of-stay reaches a defined number of days (i.e. five). When a case is identified for potential Case Management, it is referred for further evaluation to ensure the right cases are worked on at the right time to achieve the best outcomes for both the member and FHSC.

Utilization Management

The first step in utilization management begins with pre-certification. The enrollee (or his/her physician or hospital) will be required to notify our UM vendor, POMCO, prior to a scheduled or elective surgery or hospital admission. The goal of precertification is to eliminate medically inappropriate outpatient services and to identify cosmetic, experimental and investigational procedures.

The requirement for pre-certification is waived in the case of an emergency admission although the certification must take place within a specified time period. POMCO will also accept and encourage prior approval for

services not requiring precertification. This aids in mapping network affiliation, out of network negotiation, early identification of potential high dollar cases, and serves to promote quality and delivery of services.

Upon notification of a pending or ongoing hospital admission, or outpatient procedure, a certified registered nurse will contact the attending physician or the hospital UR department to request appropriate clinical information necessary to perform the initial medical necessity review. The review nurse compares the information received to our clinical review criteria, which are based on nationally accepted standards. If the information provided does not meet the medical necessity requirements, the case is forwarded to POMCO's Peer Medical Consultant Panel for review. POMCO has a proactive approach to peer review. In all instances there is a peer specialty match and the physician peer initiates an outreach to the requesting physician.

If the information meets medical necessity requirements, the review nurse authorizes the admission and assigns an initial length of stay. Cases for which Case Management or outpatient treatment could eliminate the need for hospitalization, are identified and addressed in the appropriate manner. This may be done verbally and by written notifications to the member/patient, attending physician and medical treatment facility. The notification includes the number of initial days authorized and instructions as to how an extension may be requested if needed.

POMCO will also be responsible for concurrent review. A review is performed via telephone with the attending physician and /or the hospital UR nurse. POMCO utilizes InterQual criteria or nationally recognized criteria. All cases that do not meet InterQual criteria or cases that meet a discharge screen would be referred to our Peer Review Panel for additional review.

POMCO and the FHSC Medical Director will develop the pre-certification list, and will review (and perhaps modify) at least annually. The initial list will draw from POMCO's existing list of historically high cost or over-utilized procedures and treatments, as well as certain procedures that the FHSC Medical Director hopes to monitor.

Quality Assurance and Quality Initiatives

On a weekly basis, the FHSC Medical Director will review selected indicators prepared by the POMCO Medical Services department together with the POMCO designee. This review will explore claims experience, case management activity, utilization by population and provider type, etc. Out of these weekly meetings, initiatives to improve quality and cost-effectiveness will be identified and the team will determine how to implement the recommended improvements.

Medical Homes

As FHSC continues to build its provider network and learns about the quality and capabilities of primary care providers in the MagnaCare network, new payment and medical management practices will be introduced to improve population health, adherence to evidence-based care, wellness promotion, transitions of care.

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional

An important priority for FHSC is to minimize – if not eliminate – the rate of patients who are readmitted within 30 days of leaving the hospital (180 days for psychiatric admissions). The measurement standard will be HEDIS based**.**

The discharge planning process starts with concurrent review of every hospitalized patient, when the first clinical review is received by the utilization review nurse. The case is triggered to POMCO's Case Management for follow-through with identifying discharge needs and assisting in arranging necessary services so that discharge is not unnecessarily delayed

The POMCO Case Manager will work with the hospital discharge planners to ensure that home care, medications, and other needed services are in place for discharge, and then will follow-up with those providers to ensure that they have been initiated. If social issues may present a risk for re-admission, the POMCO Case Manager will make a referral to an appropriate social service agency as well.

Then, once the patient is discharged, the FHSC "Health Maximization Program" (see the wellness section below) will receive an automated notice from POMCO UM. One of the Health Coaches will contact the member, likely by telephone, and work with them to arrange a post-discharge appointment with their primary care provider (and/or with their specialist if appropriate), then help the member arrange transportation and accompaniment if needed. The member will receive a reminder notification the morning of their follow-up appointment.

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

The FHSC Medical Director will be the primary liaison with our MagnaCare providers and with the primary care providers with whom we contract directly. Drawing on the weekly and monthly reports provided by POMCO, the Medical Director will have the data to identify opportunities to improve adherence to best clinical practices and evidence-based protocols. He will then reach out to our network providers – in some cases, collaborating

with the MagnaCare Medical Director – to educate and incentivize the providers to modify their treatment plans.

In some cases, the data may indicate a particular provider with quality concerns. In those cases, the FHSC Medical Director will then work with MagnaCare to either: provide feedback and education to a particular provider; eliminate a provider of concern from the FHSC network; or combine those activities to ensure patient safety and quality of care.

On a prospective basis, FHSC will rely on POMCO's utilization management for assistance with evidence-based protocol adherence. Initiated by pre-certification, the POMCO staff will apply Interqual Criteria Guidelines, POMCO Proprietary Medical Criteria, and/or Medicare Guidelines to get to a determination. If the review criterion is not met at the nurse reviewer level, then the case is forwarded to an independent physician reviewer. If the planned course of treatment continues to fail to meet the criteria, the member and/or provider are provided options or alternative levels of care for consideration.

FHSC will also pay particular attention to patient safety and medical errors. Working with both POMCO and MagnaCare, the FHSC Medical Director will develop processes for sentinel event/adverse outcome reporting and monitoring; he will also monitor quality of care complaints directly from the members. Providers with events and complaints exceeding established thresholds will be contacted and education and/or elimination will follow. Serious Reportable Adverse Events (Never Events) will result in action on a case by case basis.

(D) the implementation of wellness and health promotion activities;

A key feature of FHSC is its emphasis on proactive health and wellness. Under its "Health Maximization Program (temporary name)" members will not only have access to information and support to improve health behaviors, but also receive encouragement and assistance to utilize primary care, supportive services and medications appropriately.

Upon enrollment, all members – regardless of their interest in Wellness -- will need to establish an account on the FHSC website. Using that opportunity, members will be offered small incentives, such as a Jamba Juice card, to complete a Health Risk Assessment. We will use a proven assessment tool that covers demographic, biometric, lifestyle, psychological and readiness for change, among other questions. The health risk assessment will:

- Populate the data warehouse, to be used for "push notifications" described below;
- Provide the member with summary feedback, including areas for improvement;
- Allow members to voluntarily sign up with for Health Coaching support.

For those members who sign up for Health Coaching through the Health Risk Assessment mechanism, a Health Coach will contact them by phone and, first, help them to arrange a primary care appointment. The Coach will provide the member with suggested "talking points" and questions to bring to the appointment, so that they can make the most of their first encounter. The Coach will also offer to role play with the member, to better prepare them for their interactions with their physician.

While the primary goal of the Health Coach will be to initiate effective primary care relationships for the members, the Health Coaching program assumes additional responsibilities. First, the Health Coaches will recommend certain supportive services and then help members locate either exercise programs, nutritionists, smoking cessation programs, weight loss programs, alternative care providers and other resources relevant to their needs. (Such resources will be made available to FHSC members at a substantial discount, through a relationship with a national network.) The Coach may again offer talking points and questions to assist the member in their first encounter with these supportive service providers.

Whether or not a member is interested in formal supportive programs, the Health Coaching program will assist them in identifying literature, useful tools and websites that can assist the member with their particular issue(s) or concern(s).

Note that some members will meet eligibility for the Case Management program, described in an earlier section. During that first phone conversation, the Health Coach will encourage those members to participate in the relevant program.

We expect that some members will be resistant to physician visits, supportive services, case management, or behavior change. Therefore, the Health Coaches will be trained in special coaching techniques and motivational interviewing to help members understand how health behaviors impact their own goals, work through ambivalence, and commit to first steps. The Health Coaches will maintain records on each member they assist, and follow-up on a quarterly basis to help them connect to the resources and/or behavior changes they need. This may be by phone, text or email, depending on the member's preference.

Of course, there will be many members that do not participate in the Health Coaching program, and FHSC is still committed to maximizing their health and wellness. An important feature of FHSC is its data warehouse and business intelligence. All demographic, diagnosis, claims and prescription fill/refill data (as well as the health risk assessment, to the extent its available) will reside in the warehouse. From that, reports will be generated to identify populations due for preventive services, experiencing certain gaps in care, or other needs.

Under the direction of the FHSC Medical Director, the Health Maximization program will create "push notifications," reminding members of specific health services they should seek out or providing advice on managing their health. Depending on the issue and the size of the population, push notifications can be my mail, email, text or phone calls from the Health Coaches. Some examples may include:

- Reminders about screening tests, such as mammograms or colonoscopy, for those who fit the criteria and have not had one in a year or more.

- Encouragement for a comprehensive physical, for those who have had no primary care encounters within a specified time period.

- Health education materials pertinent to different groups of members, or even the overall membership. Mailings might cover such topics as “starting an exercise program,” “taking care of yourself during cold and flu season,” “fitting fruits and vegetables in your diet,” etc.

- Suggestions for self-management (such as nutrition guidelines and quarterly lab tracking tools) for those with chronic conditions such as diabetes, hyperlipidemia, HIV/AIDS, etc.

Depending on the relationships that FHSC has with its providers, selected communications may also be sent to the designated primary care provider, such as gaps in prescription-filling or visits to an Emergency Department. The Health Coaching can also be made available to providers who request such assistance on these cases.

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings; and

As a New York health plan, FHSC anticipates enrolling members across all races and ethnicities, including many immigrants. In fact, our target market of self-employed is disproportionately represented by foreign-born individuals, especially those speaking Cantonese/Mandarin, Spanish, Korean, and Arabic. We therefore will produce the Member Handbook and member communications in these languages, and employ customer service representatives that speak these languages. In cases where members need assistance in other languages, we will utilize an on-call translation vendor, such as ATT language services, to ensure our members can communicate their questions and concerns without any language barriers.

Moreover, as a COOP, we are mandated to engage our members in a dialogue on their needs and our operations; we anticipate doing this through community outreach events, which will be staffed by those fully competent in Hispanic, Asian, and Arabian culture and customs.

FHSC is committed to reducing disparities in health care and will seek to engage partners, members and providers in the process. Standard reports coming out of the FHSC data warehouse and business intelligence will monitor utilization and outcomes across race, primary language and other features, and disparities will trigger performance improvement efforts involving POMCO, MagnaCare and FHSC.

(F) a description of any current or proposed innovative programs to expand access to mental health services including but not limited to telepsychiatry or consultative services for co-management of common behavioral health conditions in children and adults.

Within Case Management, POMCO's Psychiatric/Substance Abuse Specialists will seek to assist with transitions from inpatient care to step-down settings and provide medical necessity determinations regarding the appropriateness of outpatient day treatment programs and assess levels of psychosocial support of the patient. The Case Manager may assist with identifying community resources such as Meals on Wheels, or may link the patient with community support groups.

As part of the standard and supplemental health risk appraisals offered to every member, we will include a series of well validated behavioral risk inventories. Data from these inventories will be used to engage members in early referral to mental health services.

Attachment B
Freelancers Health Service Corporation

Benefit Designs - Without Pediatric Dental

Essential Care Plans and Essential Care Age 29 Option Plans

Product Name	EssentialCare Platinum	EssentialCare Gold	EssentialCare Silver	EssentialCare Bronze	EssentialCare Catastrophic*
Exchange Status	On and Off	On and Off	On and Off	On and Off	On and Off
Plan ID	71644NY0010004	71644NY0010003	71644NY0010002	71644NY0010001	71644NY0010005
Metal Tier	Platinum	Gold	Silver	Bronze	Catastrophic
Deductible	$0	$600	$2,000	$3,000	$6,350
Co-insurance	100%	100%	100%	50%	100%
Out-of-Pocket Max	$2,000	$4,000	$5,500	$6,350	$6,350
ER Services	$100 after deductible is met	$150 after deductible is met	$150 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
IP Hospital/Skilled Nursing Facility	$500 after deductible is met	$1,000 after deductible is met	$1,500 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Office Visits – Primary and MHSA	$15 after deductible is met	$25 after deductible is met	$30 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Office Visits – Specialist, Imaging, Lab, X-Rays	$35 after deductible is met	$40 after deductible is met	$50 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
PT/ST/OT	$25 after deductible is met	$30 after deductible is met	$30 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Facility Fee	$100 after deductible is met	$100 after deductible is met	$100 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery Charge	$100 after deductible is met	$100 after deductible is met	$100 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Rx Cost Share	$10/$30/$60	$10/$35/$70	$10/$35/$70	$10/$35/$70	Deductible & Coinsurance
Pediatric Dental	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Actuarial Value	88.1%	79.0%	70.7%	62.0%	58.0%
AV Requirement	88-92%	78-82%	68-72%	58-62%	< 58%

** No Age 29 Option available on Catastrophic plans*

FHSC Select Plans

Product Name	Primary Select Platinum	Primary Select Gold	Primary Select Silver	Primary Select Bronze
Exchange Status	On and Off	On and Off	On and Off	On and Off
Plan ID	71644NY0030004	71644NY0030003	71644NY0030002	71644NY0030001
Metal Tier	Platinum	Gold	Silver	Bronze
Deductible	$0	$250	$2,000	$6,350
Co-insurance	80%	80%	80%	100%
Out-of-Pocket Max	$1,400	$3,500	$6,350	$6,350
ER Services	$250 after deductible is met	$250 after deductible is met	$250 after deductible is met	Deductible & Coinsurance
IP Hospital/Skilled Nursing Facility	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Visits – Primary and MHSA	$0	$0	$0	$0
Office Visits – Specialist, Imaging, Lab, X-Rays	$75	$75	$75	Deductible & Coinsurance
PT/ST/OT	$30	$30	$30	Deductible & Coinsurance
Outpatient Facility Fee	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery Charge	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Rx Cost Share	$0/ $35 after Ded/$70 after Ded	$0/ $35 after Ded/$70 after Ded	$0/ $35 after Ded/$70 after Ded	Deductible & Coinsurance
Pediatric Dental	Not Covered	Not Covered	Not Covered	Not Covered
Actuarial Value	88.2%	81.7%	71.5%	61.7%
AV Requirement	88-92%	78-82%	68-72%	58-62%

FHSC Select EPO Plan

Product Name	Primary Select Silver EPO
Exchange Status	On and Off
Plan ID	71644NY0040002
Metal Tier	Silver
Deductible	$2,000
Co-insurance	80%
Out-of-Pocket Max	$6,350
ER Services	$250 after deductible is met
IP Hospital/Skilled Nursing Facility	Deductible & Coinsurance
Office Visits – Primary and MHSA	Tier 1: $0 Tier 2: $30
Office Visits – Specialist, Imaging, Lab, X-Rays	$75
PT/ST/OT	$30
Outpatient Facility Fee	Deductible & Coinsurance
Outpatient Surgery Charge	Deductible & Coinsurance
Rx Cost Share	$0/ $35 after Ded/$70 after Ded
Pediatric Dental	Not Covered
Actuarial Value	70.9%
AV Requirement	68-72%

Benefit Designs - With Pediatric Dental

EssentialCare Plans and EssentialCare Age 29 Option Plans

Product Name	EssentialCare Platinum	EssentialCare Gold	EssentialCare Silver	EssentialCare Bronze	EssentialCare Catastrophic*
Exchange Status	On and Off	On and Off	On and Off	On and Off	On and Off
Plan ID	71644NY0580004	71644NY0580003	71644NY0580002	71644NY0580001	71644NY0580005
Metal Tier	Platinum	Gold	Silver	Bronze	Catastrophic
Deductible	$0	$600	$2,000	$3,000	$6,350
Co-insurance	100%	100%	100%	50%	100%
Out-of-Pocket Max	$2,000	$4,000	$5,500	$6,350	$6,350
ER Services	$100 after deductible is met	$150 after deductible is met	$150 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
IP Hospital/Skilled Nursing Facility	$500 after deductible is met	$1,000 after deductible is met	$1,500 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Office Visits – Primary and MHSA	$15 after deductible is met	$25 after deductible is met	$30 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Office Visits – Specialist, Imaging, Lab, X-Rays	$35 after deductible is met	$40 after deductible is met	$50 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
PT/ST/OT	$25 after deductible is met	$30 after deductible is met	$30 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Facility Fee	$100 after deductible is met	$100 after deductible is met	$100 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery Charge	$100 after deductible is met	$100 after deductible is met	$100 after deductible is met	Deductible & Coinsurance	Deductible & Coinsurance
Rx Cost Share	$10/$30/$60	$10/$35/$70	$10/$35/$70	$10/$35/$70	Deductible & Coinsurance
Pediatric Dental	Covered	Covered	Covered	Covered	Covered
Actuarial Value	88.1%	79.0%	70.7%	62.0%	58.0%
AV Requirement	88-92%	78-82%	68-72%	58-62%	< 58%

** No Age 29 Option available on Catastrophic plans*

FHSC Select Plans

Product Name	Primary Select Platinum	Primary Select Gold	Primary Select Silver	Primary Select Bronze
Exchange Status	On and Off	On and Off	On and Off	On and Off
Plan ID	71644NY0600004	71644NY0600003	71644NY0600002	71644NY0600001
Metal Tier	Platinum	Gold	Silver	Bronze
Deductible	$0	$250	$2,000	$6,350
Co-insurance	80%	80%	80%	100%
Out-of-Pocket Max	$1,400	$3,500	$6,350	$6,350
ER Services	$250 after deductible is met	$250 after deductible is met	$250 after deductible is met	Deductible & Coinsurance
IP Hospital/Skilled Nursing Facility	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Visits – Primary and MHSA	$0	$0	$0	$0
Office Visits – Specialist, Imaging, Lab, X-Rays	$75	$75	$75	Deductible & Coinsurance
PT/ST/OT	$30	$30	$30	Deductible & Coinsurance
Outpatient Facility Fee	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery Charge	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Rx Cost Share	$0/ $35 after Ded/$70 after Ded	$0/ $35 after Ded/$70 after Ded	$0/ $35 after Ded/$70 after Ded	Deductible & Coinsurance
Pediatric Dental	Covered	Covered	Covered	Covered
Actuarial Value	88.2%	81.7%	71.5%	61.7%
AV Requirement	88-92%	78-82%	68-72%	58-62%

FHSC Select EPO Plan

Product Name	Primary Select Silver EPO
Exchange Status	On and Off
Plan ID	71644NY0610002
Metal Tier	Silver
Deductible	$2,000
Co-insurance	80%
Out-of-Pocket Max	$6,350
ER Services	$250 after deductible is met
IP Hospital/Skilled Nursing Facility	Deductible & Coinsurance
Office Visits – Primary and MHSA	Tier 1: $0 Tier 2: $30
Office Visits – Specialist, Imaging, Lab, X-Rays	$75
PT/ST/OT	$30
Outpatient Facility Fee	Deductible & Coinsurance
Outpatient Surgery Charge	Deductible & Coinsurance
Rx Cost Share	$0/ $35 after Ded/$70 after Ded
Pediatric Dental	Covered
Actuarial Value	70.9%
AV Requirement	68-72%

Attachment A
Freelancers Health Service Corporation
Actuarial Value Calculator Outputs

Standard Platinum - 71644NY0010004

User Inputs for Plan Parameters *****STANDARD PLATINUM PLAN (3-5-2013)*****

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)	☐	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

*****STANDARD PLATINUM PLAN (3-5-2013)*****

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.1%
Metal Tier:	Platinum

Standard Gold - 71644NY0010003

User Inputs for Plan Parameters *****STANDARD GOLD PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

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	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.120%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.220%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

*****STANDARD GOLD PLAN (3-5-2013)*****

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.0%
Metal Tier:	Gold

Standard Silver - 71644NY0010002

User Inputs for Plan Parameters *****STANDARD SILVER PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,500.00					
OOP Maximum if Separate ($)						

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	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.570%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.340%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

*****STANDARD SILVER PLAN (3-5-2013)*****

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver

Standard Silver CSR 200 – 250% FPL Plan - 71644NY0010002-04

User Inputs for Plan Parameters — *****SILVER CSR 200-250% FPL PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,750.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

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	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.570%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.340%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

*****SILVER CSR 200-250% FPL PLAN (3-5-2013)*****
Per HHS Reg, AV for this plan must be at least 2 points higher than AV for corresponding regular silver plan

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.4%
Metal Tier:	Silver

Standard Silver CSR 150 – 200% FPL Plan - 71644NY0010002-05

User Inputs for Plan Parameters

*****SILVER CSR 150-200% FPL PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$250.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$2,000.00		
OOP Maximum if Separate ($)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$75.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
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	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.830%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.600%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

*****SILVER CSR 150-200% FPL PLAN (3-5-2013)*****
The 150-200% FPL plan must use the GOLD tables,
any error message is to be ignored, per AV methodology reg.

Output

Status/Error Messages:	Calculation resolved without matching metal tiers.
Actuarial Value:	86.7%
Metal Tier:	Platinum

Standard Silver CSR 100 – 150% FPL Plan - 71644NY0010002-06

User Inputs for Plan Parameters

*****SILVER CSR 100-150% FPL PLAN (3-5-2013)*****

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$1,000.00					
OOP Maximum if Separate ($)						

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	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$20.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$20.00	☑	☑		
Skilled Nursing Facility	☐	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98.480%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.760%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$6.00	☑	☑		
Preferred Brand Drugs	☐	☐		$15.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$30.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

*****SILVER CSR 100-150% FPL PLAN (3-5-2013)*****

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

Standard Bronze - 71644NY0010001

User Inputs for Plan Parameters

*****STANDARD BRONZE PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

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	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

*****STANDARD BRONZE PLAN (3-5-2013)*****

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	62.0%
Metal Tier:	Bronze

Standard Catastrophic - 71644NY0010005

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,350.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☐		
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☐	☐		
X-rays and Diagnostic Imaging	☑	☑			☐	☐		
Skilled Nursing Facility	☑	☑			☐	☐		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	58.0%
Metal Tier:	

Primary Select Platinum - 71644NY0030004

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 ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$1,400.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.2%
Metal Tier:	Platinum

Primary Select Gold - 71644NY0030003

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$250.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$3,500.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.7%
Metal Tier:	Gold

Primary Select Silver - 71644NY0030002

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to	Tier 2 Subject to	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☐ all	☐ all			☑ all	☑ all		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ all	☐ all			☑ all	☑ all		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.5%
Metal Tier:	Silver

Primary Select Silver CSR 200 – 250% FPL Plan - 71644NY0030002-04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to	Tier 2 Subject to	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.7%
Metal Tier:	Silver

Primary Select Silver CSR 150 – 200% FPL Plan - 71644NY0030002-05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,000.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.6%
Metal Tier:	Gold

Primary Select Silver CSR 100 – 150% FPL Plan - 71644NY0030002-06

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 ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.7%
Metal Tier:	Platinum

Primary Select Bronze - 71644NY0030001

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	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 ($)			$6,350.00			$6,350.00
Coinsurance (%, Insurer's Cost Share)			100.00%			100.00%
OOP Maximum ($)			$6,350.00			$6,350.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsuranc e, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsuran ce, if	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.7%
Metal Tier:	Bronze

Primary Select Silver EPO - 71644NY0040002

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	40%
		2nd Tier Utilization:	60%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			$2,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%			80.00%
OOP Maximum ($)			$6,350.00			$6,350.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible	Tier 1 Subject to Coinsuranc	Tier 1 Coinsuranc e, if	Tier 1 Copay, if separate	Tier 2 Subject to	Tier 2 Subject to	Tier 2 Coinsuran ce, if	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.3%
Metal Tier:	Silver

Primary Select Silver EPO CSR 200 – 250% FPL Plan - 71644NY0040002-04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	40%
		2nd Tier Utilization:	60%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			$2,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%			80.00%
OOP Maximum ($)			$5,200.00			$5,200.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to	Tier 2 Subject to	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.1%
Metal Tier:	Silver

Primary Select Silver EPO CSR 150 – 200% FPL Plan - 71644NY0040002-05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	40%
		2nd Tier Utilization:	60%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			$0.00
Coinsurance (%, Insurer's Cost Share)			80.00%			80.00%
OOP Maximum ($)			$2,000.00			$2,000.00
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.0%
Metal Tier:	Gold

Primary Select Silver EPO CSR 100 – 150% FPL Plan - 71644NY0040002-06

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	40%
2nd Tier Utilization:	60%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			$0.00
Coinsurance (%, Insurer's Cost Share)			80.00%			80.00%
OOP Maximum ($)			$500.00			$500.00
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

Attachment A
Freelancers Health Service Corporation
Actuarial Value Calculator Outputs

Standard Platinum - 71644NY0010004

User Inputs for Plan Parameters *****STANDARD PLATINUM PLAN (3-5-2013)*****

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)	☐	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

*****STANDARD PLATINUM PLAN (3-5-2013)*****

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.1%
Metal Tier:	Platinum

Standard Gold - 71644NY0010003

User Inputs for Plan Parameters

*****STANDARD GOLD PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

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	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.120%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.220%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

*****STANDARD GOLD PLAN (3-5-2013)*****

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.0%
Metal Tier:	Gold

Standard Silver - 71644NY0010002

User Inputs for Plan Parameters

*****STANDARD SILVER PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,500.00					
OOP Maximum if Separate ($)						

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	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.570%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.340%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

*****STANDARD SILVER PLAN (3-5-2013)*****

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver

Standard Silver CSR 200 – 250% FPL Plan - 71644NY0010002-04

User Inputs for Plan Parameters

*****SILVER CSR 200-250% FPL PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,750.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

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	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.570%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	92.340%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

*****SILVER CSR 200-250% FPL PLAN (3-5-2013)*****
Per HHS Reg, AV for this plan must be at least 2 points higher than AV for corresponding regular silver plan

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.4%
Metal Tier:	Silver

Standard Silver CSR 150 – 200% FPL Plan - 71644NY0010002-05

User Inputs for Plan Parameters

*****SILVER CSR 150-200% FPL PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$250.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,000.00					
OOP Maximum if Separate ($)						

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	☑	☐		$75.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
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	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.830%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.600%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

*****SILVER CSR 150-200% FPL PLAN (3-5-2013)*****
The 150-200% FPL plan must use the GOLD tables,
any error message is to be ignored, per AV methodology reg.

Output

Status/Error Messages:	Calculation resolved without matching metal tiers.
Actuarial Value:	86.7%
Metal Tier:	Platinum

Standard Silver CSR 100 – 150% FPL Plan - 71644NY0010002-06

User Inputs for Plan Parameters

*****SILVER CSR 100-150% FPL PLAN (3-5-2013)*****

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	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$1,000.00					
OOP Maximum if Separate ($)						

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	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$20.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$20.00	☑	☑		
Skilled Nursing Facility	☐	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98.480%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.760%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$6.00	☑	☑		
Preferred Brand Drugs	☐	☐		$15.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$30.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

*****SILVER CSR 100-150% FPL PLAN (3-5-2013)*****

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

Standard Bronze - 71644NY0010001

User Inputs for Plan Parameters

*****STANDARD BRONZE PLAN (3-5-2013)*****

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

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	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

*****STANDARD BRONZE PLAN (3-5-2013)*****

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	62.0%
Metal Tier:	Bronze

Standard Catastrophic - 71644NY0010005

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	60%
		2nd Tier Utilization:	40%

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,400.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$6,400.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsuranc e, if	Tier 1 Copay, if separate	Tier 2 Subject to	Tier 2 Subject to	Tier 2 Coinsuran ce, if	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	57.8%
Metal Tier:	

Primary Select Platinum - 71644NY0030004

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 ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$1,400.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.2%
Metal Tier:	Platinum

Primary Select Gold - 71644NY0030003

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$250.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$3,500.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.7%
Metal Tier:	Gold

Primary Select Silver - 71644NY0030002

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,400.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.5%
Metal Tier:	Silver

Primary Select Silver CSR 200 – 250% FPL Plan - 71644NY0030002-04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to	Tier 2 Subject to	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☐ all	☐ all			☑ all	☑ all		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ all	☐ all			☑ all	☑ all		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.7%
Metal Tier:	Silver

Primary Select Silver CSR 150 – 200% FPL Plan - 71644NY0030002-05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,000.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.6%
Metal Tier:	Gold

Primary Select Silver CSR 100 – 150% FPL Plan - 71644NY0030002-06

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 ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$75.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.7%
Metal Tier:	Platinum

Primary Select Bronze - 71644NY0030001

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	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 ($)			$6,350.00			$6,350.00
Coinsurance (%, Insurer's Cost Share)			100.00%			100.00%
OOP Maximum ($)			$6,350.00			$6,350.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsuranc e, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsuran ce, if	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.7%
Metal Tier:	Bronze

Primary Select Platinum EPO - 71644NY0040004

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:	90%
		2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			$0.00
Coinsurance (%, Insurer's Cost Share)			80.00%			80.00%
OOP Maximum ($)			$1,400.00			$1,400.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	88.1%
Metal Tier:	Platinum

Primary Select Gold EPO - 71644NY0040003

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	40%
		2nd Tier Utilization:	60%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$250.00			$250.00
Coinsurance (%, Insurer's Cost Share)			80.00%			80.00%
OOP Maximum ($)			$3,500.00			$3,500.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.4%
Metal Tier:	Gold

Primary Select Silver EPO - 71644NY0040002

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	40%
2nd Tier Utilization:	60%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			$2,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%			80.00%
OOP Maximum ($)			$6,400.00			$6,400.00
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.8%
Metal Tier:	Silver

Primary Select Silver EPO CSR 200 – 250% FPL Plan - 71644NY0040002-04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Bloated Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	40%
		2nd Tier Utilization:	60%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			$2,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%			60.00%
OOP Maximum ($)			$5,200.00			$5,200.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to	Tier 2 Subject to	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.1%
Metal Tier:	Silver

Primary Select Silver EPO CSR 150 – 200% FPL Plan - 71644NY0040002-05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	40%
		2nd Tier Utilization:	60%

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$0.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$2,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$0.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$2,000.00
OOP Maximum if Separate ($)			

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.0%
Metal Tier:	Gold

Primary Select Silver EPO CSR 100 – 150% FPL Plan - 71644NY0040002-06

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	40%
2nd Tier Utilization:	60%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			$0.00
Coinsurance (%, Insurer's Cost Share)			80.00%			80.00%
OOP Maximum ($)			$500.00			$500.00
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☐ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$30.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$75.00	☐	☐		$75.00
X-rays and Diagnostic Imaging	☐	☐		$75.00	☐	☐		$75.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☐ All	☐ All		
Generics	☐	☐		$0.00	☐	☐		$0.00
Preferred Brand Drugs	☑	☐		$35.00	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☐		$70.00	☑	☐		$70.00
Specialty Drugs (i.e. high-cost)	☑	☐		$70.00	☑	☐		$70.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

Primary Select Bronze EPO - 71644NY0040001

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	40%
		2nd Tier Utilization:	60%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,350.00			$6,350.00
Coinsurance (%, Insurer's Cost Share)			100.00%			100.00%
OOP Maximum ($)			$6,350.00			$6,350.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsuranc e, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsuran ce, if	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐			☐	☐		$30.00
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐			☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.2%
Metal Tier:	Bronze

Exhibit 8 - Index Rate / Plan Design Level Adjustment Worksheet

Company Name: [Highlighted in light blue] Anthem Health Plans of Virginia
NAIC Code: [Highlighted in light blue] 54836
SERFF Number: [Highlighted in light blue] [illegible]
Market Segment: [Highlighted in light blue] Individual

Separate columns for each plan design (or on-off-Exchange).

General

| Line # | | |

Exhibit 8 - Index Rate / Plan Design Level Adjustment Worksheet

Company Name: Freelancers Health Service Corporation
NAIC Code: 999999
SERFF Number:
Market Segment: Individual

Separate column for each plan design (on or off Exchange)

Line #	General					
1	Product*	Essential Care	Essential Care	Essential Care	Essential Care	Essential Care
2	Product ID*	71644NY001	71644NY001	71644NY001	71644NY001	71644NY001
3	Metal Level (or catastrophic)*	Platinum	Gold	Silver	Bronze	Catastrophic
4	AV Metal Value (HHS Calculator)*	0.881	0.790	0.707	0.620	0.578
5	AV Pricing Value (total, risk pool experience based)*	2.014	1.713	1.513	1.199	0.831
6	Plan Type*	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Essential Care Platinum Plan	Essential Care Gold Plan	Essential Care Silver Plan	Essential Care Bronze Plan	Essential Care Catastrophic Plan
8	Plan ID*	71644NY0010004	71644NY0010003	71644NY0010002	71644NY0010001	71644NY0010005
9	Exchange Plan?*	Yes	Yes	Yes	Yes	Yes

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate					
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools] for Latest Experience Period	111275576.615				
10B	Member-Months for Latest Experience Period	337218.000				
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	329.98				
11	Average Pricing Actuarial Value reflected in experience period	0.780				
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**

Market Wide Adjustments to the AV
Adjusted Experience Period Index Rate

13	Impact of adjusting experience period data to EHB benefit level	1.000				
14	Market wide adjustment for changes in provider network **	1.000				
15	Market wide adjustment for fee schedule changes **	1.000				
16	Market wide adjustment for utilization management changes **	1.000				
17	Impact on risk pool of changes in expected covered membership risk characteristics **	0.866				
18	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	1.000				
19	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000				
20	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	1.000				
21	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.893				
22	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000				
23	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.050				
24	Other 1 (specify)	1.000				
25	Other 2 (specify)	1.000				
26	Other 3 (specify)	1.000				
27	**Impact of Market Wide Adjustments (product L13 through L26)**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**

** Not Included in Claim Trend Adjustment

Plan Level Adjustments

28	Pricing actuarial value (without induced demand factor) #	0.924	0.837	0.751	0.633	0.591
29	Pricing actuarial value (only the induced demand factor) #	1.150	1.080	1.063	1.000	1.000
30	Impact of provider network characteristics ##	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
32	Impact of utilization management practices ##	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
34	Administrative costs (excluding Exchange user fees and profits)	1.317	1.317	1.317	1.317	1.317
35	Profit/Contribution to surplus margins	0.974	0.974	0.974	0.974	0.974
36	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	0.741
37	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000
38	Impact of Adjustment for Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000
39	Impact of Pediatric Dental	1.000	1.000	1.000	1.000	1.000
40	Child Only Demographics	1.000	1.000	1.000	1.000	1.000
41	**Impact of Plan Level Adjustments (product L28 through L40)**	**1.363**	**1.160**	**1.024**	**0.812**	**0.562**

Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

42	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L27 x L41)**	**468.12**	**398.13**	**351.61**	**278.73**	**193.07**

Essential Care Child Only	Essential Care Child Only	Essential Care Child Only	Essential Care Child Only	Primary Select	Primary Select	Primary Select	Primary Select	Primary Select EPO	EssentialCare Pediatric Dental
71644NY002	71644NY002	71644NY002	71644NY002	71644NY003	71644NY003	71644NY003	71644NY003	71644NY004	71644NY058
Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze	Silver	Platinum
0.881	0.790	0.707	0.620	0.882	0.817	0.715	0.617	0.708	0.881
0.830	0.706	0.623	0.494	1.931	1.712	1.512	1.040	1.426	2.043
HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	EPO	HMO
Essential Care Platinum Child Only	Essential Care Gold Child Only Plan	Essential Care Silver Child Only	Essential Care Bronze Child Only	Primary Select Platinum Plan	Primary Select Gold Plan	Primary Select Silver Plan	Primary Select Bronze Plan	Primary Select EPO Silver Plan	EssentialCare Platinum Plan
71644NY0020004	71644NY0020003	71644NY0020002	71644NY0020001	71644NY0030004	71644NY0030003	71644NY0030002	71644NY0030001	71644NY0040002	71644NY0580004
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

423.17	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**

0.811	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**

0.924	0.837	0.751	0.633	0.936	0.884	0.793	0.580	0.793	0.924
1.150	1.080	1.063	1.000	1.150	1.080	1.063	1.000	1.063	1.150
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.944	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	0.946	0.946	0.946	0.946	0.946	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317
0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.014
0.412	0.412	0.412	0.412	1.000	1.000	1.000	1.000	1.000	1.000
0.562	**0.478**	**0.422**	**0.334**	**1.307**	**1.159**	**1.023**	**0.704**	**0.966**	**1.383**

192.87	**164.03**	**144.86**	**114.84**	**448.78**	**397.82**	**351.35**	**241.62**	**331.51**	**474.86**

EssentialCare Pediatric Dental	EssentialCare Pediatric Dental	EssentialCare Pediatric Dental	EssentialCare Pediatric Dental	EssentialCare Child Only Pediatric Dental	EssentialCare Child Only Pediatric Dental	EssentialCare Child Only Pediatric Dental	EssentialCare Child Only Pediatric Dental	PrimarySelect Pediatric Dental	PrimarySelect Pediatric Dental
71644NY058	71644NY058	71644NY058	71644NY058	71644NY059	71644NY059	71644NY059	71644NY059	71644NY060	71644NY060
Gold	Silver	Bronze	Catastrophic	Platinum	Gold	Silver	Bronze	Platinum	Gold
0.790	0.707	0.620	0.578	0.881	0.790	0.707	0.620	0.882	0.817
1.741	1.541	1.217	0.837	0.842	0.717	0.635	0.502	1.960	1.740
HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
EssentialCare Gold Plan	EssentialCare Silver Plan	EssentialCare Bronze Plan	EssentialCare Catastrophic Plan	EssentialCare Platinum Child Only	EssentialCare Gold Child Only Plan	EssentialCare Silver Child Only Plan	EssentialCare Bronze Child Only	PrimarySelect Platinum Plan	PrimarySelect Gold Plan
71644NY0580003	71644NY0580002	71644NY0580001	71644NY0580005	71644NY0590004	71644NY0590003	71644NY0590002	71644NY0590001	71644NY0600004	71644NY0600003
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

423.17	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**

0.811	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**

0.837	0.751	0.633	0.591	0.924	0.837	0.751	0.633	0.936	0.884
1.080	1.063	1.000	1.000	1.150	1.080	1.063	1.000	1.150	1.080
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.946	0.946
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317
0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974
1.000	1.000	1.000	0.741	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.017	1.018	1.015	1.008	1.014	1.017	1.018	1.015	1.015	1.017
1.000	1.000	1.000	1.000	0.412	0.412	0.412	0.412	1.000	1.000
1.179	**1.043**	**0.824**	**0.567**	**0.570**	**0.486**	**0.430**	**0.340**	**1.327**	**1.178**

404.70	**358.10**	**282.95**	**194.52**	**195.64**	**166.74**	**147.54**	**116.57**	**455.51**	**404.39**

PrimarySelect Pediatric Dental	PrimarySelect Pediatric Dental	PrimarySelect EPO Pediatric Dental	Essential Care To Age 29	Essential Care To Age 29	Essential Care To Age 29	Essential Care To Age 29	EssentialCare To Age 29 Pediatric Dental	EssentialCare To Age 29 Pediatric Dental	EssentialCare To Age 29 Pediatric Dental
71644NY060	71644NY060	71644NY061	71644NY009	71644NY009	71644NY009	71644NY009	71644NY010	71644NY010	71644NY010
Silver	Bronze	Silver	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver
0.715	0.617	0.708	0.881	0.790	0.707	0.620	0.881	0.790	0.707
1.540	1.058	1.454	2.014	1.713	1.513	1.199	2.043	1.741	1.541
HMO	HMO	EPO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
PrimarySelect Silver Plan	PrimarySelect Bronze Plan	PrimarySelect EPO Silver Plan	Essential Care Platinum Plan 29	Essential Care Gold Plan 29	Essential Care Silver Plan 29	Essential Care Bronze Plan 29	EssentialCare Platinum Plan 29	EssentialCare Gold Plan 29	EssentialCare Silver Plan 29
71644NY0600002	71644NY0600001	71644NY0610002	71644NY0090004	71644NY0090003	71644NY0090002	71644NY0090001	71644NY0100004	71644NY0100003	71644NY0100002
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

423.17	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**

0.811	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**

0.793	0.580	0.793	0.924	0.837	0.751	0.633	0.924	0.837	0.751
1.063	1.000	1.063	1.150	1.080	1.063	1.000	1.150	1.080	1.063
1.000	1.000	0.944	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
0.946	0.946	0.946	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317
0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.018	1.017	1.020	1.000	1.000	1.000	1.000	1.014	1.017	1.018
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.042	**0.716**	**0.984**	**1.363**	**1.160**	**1.024**	**0.812**	**1.383**	**1.179**	**1.043**

357.84	**245.83**	**338.01**	**468.12**	**398.13**	**351.61**	**278.73**	**474.86**	**404.70**	**358.10**

EssentialCare To Age 29 Pediatric Dental	Primary Select Age 29 Option	Primary Select Age 29 Option	Primary Select Age 29 Option	Primary Select Age 29 Option	Primary Select EPO Age 29 Option	PrimarySelect Age 29 Option Pediatric Dental	PrimarySelect Age 29 Option Pediatric Dental	PrimarySelect Age 29 Option Pediatric Dental	PrimarySelect Age 29 Option Pediatric Dental
71644NY010	71644NY013	71644NY013	71644NY013	71644NY013	71644NY015	71644NY014	71644NY014	71644NY014	71644NY014
Bronze	Platinum	Gold	Silver	Bronze	Silver	Platinum	Gold	Silver	Bronze
0.620	0.882	0.817	0.715	0.617	0.708	0.882	0.817	0.715	0.617
1.217	1.931	1.712	1.512	1.040	1.426	1.960	1.740	1.540	1.058
HMO	HMO	HMO	HMO	HMO	EPO	HMO	HMO	HMO	HMO
EssentialCare Bronze Plan 29	ary Select Platinum Pl	mary Select Gold Plar	mary Select Silver Pla	ary Select Bronze Pla	y Select EPO Silver F	PrimarySelect Platinum Plan 29	PrimarySelect Gold Plan 29	PrimarySelect Silver Plan 29	PrimarySelect Bronze Plan 29
71644NY0100001	71644NY0130004	71644NY0130003	71644NY0130002	71644NY0130001	71644NY0150002	71644NY0140004	71644NY0140003	71644NY0140002	71644NY0140001
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

423.17	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**	**423.17**

0.811	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**	**0.811**

0.633	0.936	0.884	0.793	0.580	0.793	0.936	0.884	0.793	0.580
1.000	1.150	1.080	1.063	1.000	1.063	1.150	1.080	1.063	1.000
1.000	1.000	1.000	1.000	1.000	0.944	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946	0.946
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317	1.317
0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974	0.974
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1.015	1.000	1.000	1.000	1.000	1.000	1.015	1.017	1.018	1.017
1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
0.824	**1.307**	**1.159**	**1.023**	**0.704**	**0.966**	**1.327**	**1.178**	**1.042**	**0.716**

282.95	**448.78**	**397.82**	**351.35**	**241.62**	**331.51**	**455.51**	**404.39**	**357.84**	**245.83**

PrimarySelect EPO Age 29 Option Pediatric Dental
71644NY016
Silver
0.708
1.454
EPO
PrimarySelect EPO Silver Plan 29
71644NY0160002
Yes

423.17

0.811

0.793
1.063
0.944
1.000
0.946
1.000
1.317
0.974
1.000
1.000
1.000
1.020
1.000
0.984

338.01

{C640BB68-0002-0000-0000-3652C61745C6}

EXHIBIT 9 - SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN AND INCLUDED IN CURRENT RATE APPLICATION

Company Name: Freelancers Health Service Corporation (FHSC)
NAIC Code: 999999
SERFF Number:
Market Segment: IND

A. Complete a separate ROW for Metal Level/Exchange product in the current new On/Off Exchange product filing.
- Information should be for all the benefits included in that plan design (medical, drugs, etc).
- Enter the Metal Tier the On/Off Exchange product belongs to using the drop down menu, or enter a value.
- Enter the On/Off Designation using the drop down menu.
- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

B. The average claim trend is the average annualized claim trend for that used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the proposed rates and the average annual claim trend assumed.

D. This form must be submitted as an Excel file and as a PDF file.

1. Metal Level [drop down menu]	2. On/Off Exchange Designation [drop down menu]	3. Exchange Product Name	4.1 Period assumed - beginning date (MM/DD/YY)	4.2 Period assumed - ending date (MM/DD/YY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10
Platinum	On Exchange - Std	EssentialCare Platinum Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Std	EssentialCare Gold Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Std	EssentialCare Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Std	EssentialCare Bronze Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Catastrophic	On Exchange - Std	EssentialCare Catastrophic Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Platinum	On Exchange - Std	EssentialCare Platinum Child Only Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Std	EssentialCare Gold Child Only Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Std	EssentialCare Silver Child Only Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Std	EssentialCare Bronze Child Only Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Non-Std	PrimarySelect EPO Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Platinum	On Exchange - Std	Essential Care Platinum Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Std	Essential Care Gold Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Std	Essential Care Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Std	Essential Care Bronze Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Catastrophic	On Exchange - Std	Essential Care Catastrophic Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Platinum	On Exchange - Std	Essential Care Platinum Child Only Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Std	Essential Care Gold Child Only Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Std	Essential Care Silver Child Only Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Std	Essential Care Bronze Child Only Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Non-Std	Primary Select Gold Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Non-Std	Primary Select Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Non-Std	Primary Select EPO Silver Plan	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Std	EssentialCare Gold Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Std	EssentialCare Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Platinum	On Exchange - Std	Essential Care Platinum Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Std	Essential Care Gold Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Std	Essential Care Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Std	Essential Care Bronze Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%
Silver	On Exchange - Non-Std	Primary Select EPO Silver Plan 29	01/01/14	12/31/14	5.00%	3.83%	0.80%	0.00%	1.75%	1.57%	16.14%	24.09%	-2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	21.39%

EXHIBIT 9: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES INCLUDED IN CURRENT FILING

{C640BB68-0002-0000-0000-3652C61745C6}

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	On Exchange - Std	EssentialCare Platinum Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Std	EssentialCare Gold Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Std	EssentialCare Silver Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Std	EssentialCare Bronze Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Catastrophic	On Exchange - Std	EssentialCare Catastrophic Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Platinum	On Exchange - Std	EssentialCare Platinum Child Only Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Std	EssentialCare Gold Child Only Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Std	EssentialCare Silver Child Only Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Std	EssentialCare Bronze Child Only Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Non-Std	PrimarySelect EPO Silver Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Platinum	On Exchange - Std	Essential Care Platinum Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Std	Essential Care Gold Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Std	Essential Care Silver Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Std	Essential Care Bronze Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Catastrophic	On Exchange - Std	Essential Care Catastrophic Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Platinum	On Exchange - Std	Essential Care Platinum Child Only Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Std	Essential Care Gold Child Only Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Std	Essential Care Silver Child Only Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Std	Essential Care Bronze Child Only Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Non-Std	Primary Select Gold Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Non-Std	Primary Select Silver Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Non-Std	Primary Select EPO Silver Plan	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Platinum	On Exchange - Std	EssentialCare Platinum Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Std	EssentialCare Gold Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Std	EssentialCare Silver Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Std	EssentialCare Bronze Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Platinum	On Exchange - Std	Essential Care Platinum Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Std	Essential Care Gold Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Std	Essential Care Silver Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Std	Essential Care Bronze Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Platinum	On Exchange - Non-Std	PrimarySelect Platinum Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Non-Std	PrimarySelect Gold Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Non-Std	PrimarySelect Silver Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Non-Std	PrimarySelect Bronze Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Non-Std	PrimarySelect EPO Silver Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Platinum	On Exchange - Non-Std	Primary Select Platinum Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Gold	On Exchange - Non-Std	Primary Select Gold Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Non-Std	Primary Select Silver Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Bronze	On Exchange - Non-Std	Primary Select Bronze Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50
Silver	On Exchange - Non-Std	Primary Select EPO Silver Plan 29	13.70	2.86	0.00	6.26	5.61	57.73	86.16	-9.66	0.00	0.00	0.00	76.50

Data Collection Template

Company Legal Name: **Freelancers Health Service Cor** State: **NY**
HIOS Issuer ID: **71644** 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: 1/1/2012 to 12/31/2012

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$1	$1.00	100.00%
Incurred Claims in Experience Period	$1	1.00	100.00%
Allowed Claims:	$1	1.00	100.00%
Index Rate of Experience Period		$0.00	
Experience Period Member Months	1		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	12,000.00	$1.00	$1.00	1.000	1.000	1.000	1.000	12,000.00	$1.00	$1.00	244.50	$4,101.12	$83.56
Outpatient Hospital	Visits	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	1701.19	1,005.48	142.54
Professional	Visits	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	14590.92	109.80	133.51
Other Medical	Services	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	607.82	192.77	9.76
Capitation	Benefit Period	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	1.00	1.00	0.00
Prescription Drug	Prescriptions	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	5354.03	109.57	48.89
Total				$1.00							$1.00			$418.26

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$418.26	$141,046,394
Paid to Allowed Average Factor in Projection Period			0.780	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$326.16	$109,986,186
Projected Risk Adjustments PMPM			0.00	2
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$326.16	$109,986,184
Projected ACA reinsurance recoveries, net of rein prem, PMPM			39.70	13,386,368
Projected Incurred Claims			$286.46	$96,599,816
Administrative Expense Load		16.93%	60.58	20,427,200
Profit & Risk Load		-2.70%	(9.66)	(3,256,957)
Taxes & Fees		5.69%	20.34	6,857,963
Single Risk Pool Gross Premium Avg. Rate, PMPM			$357.72	$120,628,023
Index Rate for Projection Period			$418.26	
% increase over Experience Period			35671.53%	
% Increase, annualized:			1791.34%	
Projected Member Months				337,218

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RIDER TO EXTEND COVERAGE FOR YOUNG ADULTS THROUGH AGE 29

Issued By

Freelancers Health Service Corporation DBA
Health Republic Insurance of New York

This rider, which has been selected by the Contractholder, extends the eligibility of Children for coverage under Your Certificate and any applicable rider(s) thereto. All of the terms, conditions, and limitations of the Certificate to which this rider is attached also apply to this Rider, except where they are specifically changed by this rider.

1. **Young Adults Covered through Age 29.** If You selected other than Parent and Child /Children or Family coverage, Your young adult Child will be eligible for coverage through the age of 29 years when the young adult:

   A. Is unmarried;

   B. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;

   C. Lives, works, or resides in New York State or Our Service Area.

   The young adult need not live with or be financially dependent upon You or be a student in order to be covered under this rider.

   The young adult's children are not eligible for coverage under this rider.